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Retiree Open Enrollment Health Benefits Form – 2022 Plan Year

Name: _____ SS#: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Daytime Phone # _____ Email Address: _____

Instructions: Use this form to make changes to your benefit elections for the 2022 calendar year. Return the completed form via email to humanresources@aacpl.net or by mail to AACPL Human Resources, 5 Harry S. Truman Pkwy, Annapolis, MD 21401 by November 1, 2021. **Non-Medicare eligible retirees/spouses must make a plan selection and submit an enrollment form in order to continue health benefits. If you and your spouse are enrolled in Medicare and are not making any changes, no response is necessary.**

Health Care Election – Enter coverage election(s) for 2022 calendar year

Medical Plans

- ☐ Aetna Select Open Access HMO-EPO
- ☐ Aetna Open Choice PPO
- ☐ Aetna Medicare Advantage Plan (Attach copy of Medicare Card)
- ☐ No Coverage

Medical Plan Coverage Level

- ☐ Individual
- ☐ Retiree & 1 Child
- ☐ Retiree & Spouse
- ☐ Family

Split Option (Check Eligibility):

Retiree: ☐Medicare ☐Non-Medicare

Spouse: ☐Medicare ☐Non-Medicare

Dental Plans

- ☐ Cigna PPO Dental (Core)
- ☐ Cigna PPO Dental (Buy-Up)
- ☐ Cigna Dental Care (DHMO Network Dentist Required)
- ☐ No Coverage

Dental Plan Coverage Level

- ☐ Individual
- ☐ Retiree & 1 Child
- ☐ Retiree & Spouse
- ☐ Family

Vision Plan

- ☐ EyeMed Vision
- ☐ No Coverage

Vision Plan Coverage Level

- ☐ Individual
- ☐ Retiree & 1 Child
- ☐ Retiree & Spouse
- ☐ Family

Other Health Coverage? Check here ☐ if you or your dependents are covered by another insurance policy

In the section below, list all eligible individuals for whom coverage is requested

Attach copy of Marriage or Birth Certificate if you are adding dependents who were not covered in 2021

Full Name	Relationship	SS#	Gender	Birth Date
	SELF			

By signing below, I request enrollment as indicated above and agree to pay any premiums required to participate in the selected plans. I certify that any person for whom I am electing coverage meets the applicable requirements for spuose or dependent coverage under the Plan and I agree to inform the Benefits office if that changes while my election of coverage is in effect. I understand that I may change my elections only during Open Enrollment for coverage effective the next January 1, or by requesting a permitted change within 31 days of a family status change. I attest that the information provided above is complete and true to the best of my knowledge. I understand that false information will result in claim denial and possible termination fo eligibility for coverage.

Retiree Signature:_____Date _____

Return the completed form to AACPL Human Resources, 5 Harry Truman Parkway, Annapolis, MD 21401 by November 1, 2021.