Oakland County Retiree Health Enrollment Form

Last Name	First Name	MI		Date of Birth
			Married ☐ Single ☐	/ /

Home Address	City	State	Zip code

Telephone	SSN #	Employee ID #	Date of Retirement
			/ /

HEALTH PLAN OPTIONS

Select One Medical Option (non-Medicare)

- ☐ ASR Health Benefits PPO 1 + Navitus Rx
- ☐ BCBSM PPO 2 + Navitus Rx
- ☐ ASR Health Benefits PPO 3 + Navitus Rx
- ☐ BCBSM Traditional + Navitus Rx
- ☐ Health Alliance Plan + HAP Rx
- ☐ Waive Medical and Rx coverage

Select One Dental Option

- ☐ Standard Delta Dental
- ☐ Waive Dental

Select One Vision Option

- ☐ Standard BCBS Vision
- ☐ Waive Vision

Medicare Eligibility

Are you or a covered member currently enrolled in or eligible to enroll in Medicare? Yes____ No____

☐ NGS CoreSource Medicare Supplement + Navitus Rx plan

	Medicare HIC #	Part A	Part B
Retiree			
Spouse			

Are you or a covered member currently enrolled in a Medicare D prescription drug plan? Yes ☐ No ☐ _____

***Members enrolled in a Medicare D prescription drug plan may not be enrolled in the County prescription drug plan.**

COVERED MEMBERS

IMPORTANT: Include information for each member you are covering on your plan. List the last name if different from the Retirees. See reverse side of this form for childrens eligibility guidelines.

Name	SSN	Birth date	Sex	Relationship
1				
2				
3				
4				
5				

COORDINATION OF BENEFITS (COB)

Is the Retiree enrolled in any other coverage? Yes ☐ NO ☐

Type: Medical ☐ Dental ☐ Vision ☐

If yes, Carrier Name:

Policy Number:

Primary Card Holders Name:

Is your Spouse employed? Yes ☐ NO ☐

Type: Medical ☐ Dental ☐ Vision ☐

Has spouse elected employer coverage? Yes ☐ NO ☐

If yes, Carrier Name:

Policy Number:

Primary Card Holders Name:

Is any member enrolling in a County Retiree plan covered under COBRA? Yes ☐ NO ☐

If yes, list COBRA effective date and attach a copy of the COBRA election form: _____

Is there a Court Order for any child listed above that states which parent is responsible for providing health insurance? Yes ☐ NO ☐ If Yes, attach a copy of the Court Order and answer the following:

1. Who is responsible for the health care coverage for the child(ren) listed? Mother ☐ Father ☐ Both ☐
2. Who has physical custody of the child(ren) listed? Mother ☐ Father ☐ Other ☐

CONTINUE →

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing below as a Retiree or dependent, I authorize the use or disclosure of my individually identifiable health information by or to any family members, any health care provider, the plan sponsor, the insurer/TPA of the plan or any other entity providing services in connection with the plan in order to process my enrollment in the plan or to process any claim for my plan benefits. This authorization is effective until the date I terminate enrollment in the plan. Further, I have read and understand the following: 1) I may revoke this authorization at any time before its expiration date by notifying the plan in writing, but the revocation will not have any effect on any actions the plan took before it received the revocation; 2) I may see and copy the information described on this authorization if I ask for it; 3) I am not required to sign this authorization to receive my health care benefits (enrollment, treatment or payment) and 4) The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Retiree Signature:	Date:
Spouse Signature:	Date:
Dependent Signature**:	Date:
Dependent Signature**:	Date:
Dependent Signature**:	Date:

**Children age 18 or older should sign on the "Dependent Signature" line. Minor children are not required to sign this form.

ADDITIONAL INFORMATION

Children of the Retiree by birth or legal adoption may be covered through the end of the year in which they have their 26th birthday. If a child does not meet the above criteria, they may only be covered if the Retiree is directed to do so by a Qualified Medical Child Support Order and the Retirement Unit of the Human Resources Department has been provided with the appropriate and current documentation. Children by birth or legal adoption of the Retirees spouse (stepchildren of the Retiree) may be covered through the end of the year in which they have their 26th birthday.

Disabled children of the Retiree may be covered to any age if the child became totally and permanently disabled prior to age 19; **AND** They are incapable of self-sustaining employment; **AND** The Retiree provides over half their total support as defined by the Internal Revenue Code; **AND** Their disability has been certified by a physician and the health carrier is notified in writing by the end of the year in which the child turns age 19 (or age 26 in the case of dependent continuation).

Legal Guardianship children of the Retiree may be covered through the end of the year in which they have their 26th birthday if they are unmarried; AND Their legal residence is with you; AND You supply over half their total support as defined by the Internal Revenue Code; AND You provide up to date legal guardianship papers through age 26. Coverage for children of whom you are the Legal Guardian may only continue as long as the legal guardianship is in effect.

Oakland County allows for the legal spouse of a Retiree to be covered under your Retirement benefits. If you have an order of legal separation your spouse is not eligible to continue being covered by your County retiree health plan and must be removed.

At such time that your spouse or child no longer meets the eligibility criteria, you must notify the Retirement office or complete a Membership and Record Change form included in this package and return it to the Retirement Unit of the Human Resources Department.

If you have elected coverage through a health maintenance organization (HMO), you and your covered dependents agree that all your medical services must be performed, prescribed, directed or authorized by your designated primary care physician(s) except in the case of accidental injury or life-threatening medical emergency, when it is not possible or practical to contact your designated primary care physician.

RETIREE/SUBSCRIBERS SIGNATURE

I apply on behalf of myself and eligible family members as listed for enrollment in the health plan selected above. I hereby revoke all previous enrollment applications executed by me for Oakland County hospital and medical coverage. I realize I am electing a plan not a specific carrier. I understand if I elect to Waive any portion of my health coverage my next opportunity to re-enroll could be up to one (1) year. I certify the above information is true and correct to my knowledge and belief and understand improperly enrolling or continuing coverage for an ineligible spouse or child may result in recovery of improperly paid claims.

_____

Subscriber/Retiree Signature Date

THIS SECTION FOR OFFICE USE ONLY

Effective Date_____ Group Signature_____ Group/Div_____

Notes/Comments: