

Anne Arundel County Government Retiree Open Enrollment Health Benefits Form – 2025 Plan Year

Name:		_ SS #:	Da	ate of Birth:	
Address:					
		Email Address:			
Instructions: Use this form to make changes the Office of Personnel, Benefits Team, P.O. Eare not making any changes. If you do not send it	Box 6675, Anna	polis, MD 21401 by O	ctober 31, 2024	l. No response	
Health Care Election- Enter coverage election(s) for 2025 calendar year					
Medical Plans ☐ Aetna Open Choice PPO ☐ Open Access Aetna Select HMO-EPO ☐ AETNA PPO Extended Service Area (ESA) (Attach copy of Medicare Card) ☐ No Coverage**		Medical Plan Coverage Level Individual Retiree & 1 Child Retiree & Spouse Family Split Option: Retiree's Plan Name Retiree's Spouse Plan Name:			
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 2024.					
Full Name	Relationship SELF	Social Securi	ty Number	Gender	Birth Date
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 spouse or dependent coverage under the Plan and I agree to inform the Benefits Team 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 of eligibility for coverage. Retiree Signature: Date: **Return the completed form to the Office of Personnel, Benefits Team, PO Box 6675, Annapolis, MD 21401 or send via email to: benefits_team@aacounty.org by October 31, 2024. For Personnel Use Only: Effective Date – 1/1/2025					

ADP:_____ RX:____ CIGNA:____ HWSE:____ Aet/Pru/MD:____ Entry: ____ Verify:____