RETIREE HEALTH ENROLLMENT/CHANGE FORM

CO-744-OE REV. 1/2023

State of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services
Division Retirement Health Insurance Unit
165 Capitol Ave.
Hartford, CT 06106-1775
www.osc.ct.gov

Type or print and forward to the Retirement Health Insurance Unit.

You must submit a completed enrollment application and any required documentation to the Retirement Health Insurance Unit **within 30 days** of your initial benefits eligibility date or **within 30 days** of a qualified change in family status. Please refer to https://carecompass.ct.gov for your annual Health Care Options Planner for more information.

① Your Personal Information

Retiree/Survivor Last Name	**First Name, MI**	**Retirement Date**	**Employee Number** (From Active Employment)

Street Address (no P.O. boxes)	**City**	**State**	**Zip Code**

Social Security Number	**Date of Birth** (MM/DD/YYYY)	**Gender**	**Home Telephone Number**

Email Address	**Cell/Mobile Telephone Number**

② Application Type

☐ New Retirement Enrollment
☐ Annual Open Enrollment
☐ Adding/Dropping Dependents

Qualifying Status Change:
☐ Marriage
☐ Birth/Adoption
☐ Change in Dependent Eligibility Status

Date of Event: ____/ ____/ _____
☐ Start of Other Coverage
☐ Loss of Other Coverage
☐ Death of Spouse/Dependent

③ Your Medicare Information

Complete this section if you are eligible for Medicare and would like to enroll in state-sponsored medical and prescription coverage. If you are not yet eligible for Medicare, leave this section blank.

Medicare Claim Number (as it appears on your card)	**Medicare Part A Effective Date** (MM/DD/YYYY)	**Medicare Part B Effective Date** (MM/DD/YYYY)	**End Stage Renal Diagnosis** ☐ **Yes** ☐ **No**

④ Choose Non-Medicare Medical Plan

Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records.

☐ Primary Care Access [POE-G Plus]
☐ Standard Access [POE]
☐ Quality First Select Access [Prime Plus/Tiered POS] **new**
☐ Expanded Access [POS]
☐ Anthem State Preferred POS – **Currently Enrolled Only**
☐ Anthem Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**
☐ No Change – Keep Current Medical Benefit Plan
☐ Waive/Cancel Medical and Prescription Coverage

⑤ Choose Your Dental Plan

☐ Basic Dental Plan ☐ Enhanced Dental Plan ☐ Total Care DHMO Plan ☐ Cigna DHMO Plan ☐ Waive/Cancel Dental Coverage ☐ No Change – Keep Current Dental Plan

⑥ Spouse/Dependent Information

List all of your dependents to be enrolled or dropped in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

Name	**Relationship**	**Gender**	**Date of Birth**	**Social Security Number**	**Medical**		**Dental**	
					Add	**Drop**	**Add**	**Drop**
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

⑦ Dependent Medicare Information

List all Medicare eligible dependents, attach additional sheet if necessary. If no dependents are eligible for Medicare, leave this section blank.

Name	**Medicare Claim Number** (as it appears on Medicare card)	**Medicare Part A Effective Date** (MM/DD/YYYY)	**Medicare Part B Effective Date** (MM/DD/YYYY)	**End Stage Renal Diagnosis** ☐ **Yes** ☐ **No**

⑧ Signature & Authorization

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services may be subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief. I understand that providing false and/or incomplete information may result in the loss of coverage and/or nonpayment of claims for me or my eligible dependent(s). It is my responsibility to notify the Office of the State Comptroller when a dependent becomes ineligible. I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check and/or bill me as necessary for the medical and/or dental insurance indicated above.

Retiree/Survivor Signature	**Date**