RETIREE HEALTH ENROLLMENT/CHANGE FORM

CO-744-OE REV.4/2025

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

For Open Enrollment Use Only

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

Please refer to 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

☒ Annual Open Enrollment	**Enrollment Change: Select which changes you are making** ☐ Medical Plan ☐ Dental Plan ☐ Dependent Change

③ 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] Only if Retiree's Permanent Residence is IN Connecticut
- ☐ 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**
- ☐ Waive Medical Coverage

④ Choose Your Dental Plan

☐ Basic Dental Plan ☐ Enhanced Dental Plan ☐ Total Care DHMO Plan ☐ Dental HMO Plan **Currently Enrolled Only** ☐ Waive Dental Coverage

⑤ 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

⑥ Signature and 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**

Please complete this form and email to osc.rethealth@ct.gov