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 <u>carecompass.ct.gov</u> for your annual Health Care Options Planner for more information.

Street Address (no P.O. boxes) City State Zip Code Social Security Number Date of Birth (MM/DD/YYYY) Gender Home Telephone Number Cell/Mobile Telephone Number Email Address Cell/Mobile Telephone Number Enrollment Change: Select which changes you are making Medical Plan Dental Plan Dependent Change 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 [Pime Plus/Tiened Pos] Only if Retiree's Permanent Residence is In Connecticut Choose Your Dental Plan Enhanced Dental Plan Total Care DHMO Plan Currently Enrolled Only 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 ell dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent with may be obtained from the Retirement Health Insurance Unit.	① Your Personal Information									
Social Security Number	Retiree/Survivor Last Name	First Name, MI			1	Retirement Date		Employee Number (From Active Employment)		
### Application Type ### Enrollment Change: Select which changes you are making ### Annual Open Enrollment Medical Plan Dental Plan Dependent Change ### 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. ### 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. ### Choose Your Bental Plan	Street Address (no P.O. boxes)				(City			State	Zip Code
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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 or 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 bill me as necessary for the medical and/or dental insurance indicated above.	List all of your dependents to be enrolle dependents. Attach sheets to list addition	d or dr onal dep	pendents. If any listed de							
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	Retiree/Survivor Signature			Date						

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

