Housing Authority of Baltimore City – Benefits Enrollment/Change Form – RETIREE

Internal Use Only: HABC Administrator Signature: _____ Group #: _____ Effective Date: _____

Name (Last, First, MI):	Social Security Number:
Street Address: Apt. #	Date of Birth:
City, State, Zip:	Retirement Date:
Home Phone: Business Phone:	Email:
Male☐ Female☐ Single ☐ Married ☐ Divorced ☐ Are you the: Retiree ☐ Spouse ☐	Reason for Change: _____

MEDICAL AND PRESCRIPTION DRUG (CHECK ONE)

	Individual	Parent & Child	Employee & 1 Adult	Family
Kaiser HMO Retiree (Under 65 Non-Medicare)	☐	☐	☐	☐
Kaiser HMO Medicare Advantage (Over age 65)	☐	☐	☐	☐
CareFirst BlueChoice POS (Medical & Rx)	☐	☐	☐	☐
CareFirst BlueChoice POS (Medical Only)	☐	☐	☐	☐
CareFirst Standard over 65 (Medical & Rx)	☐	☐	☐	☐
CareFirst Standard over 65 (Medical Only)	☐	☐	☐	☐

DENTAL (CHECK ONE)

The Dental Network DHMO	☐	☐	☐	☐
CareFirst Dental PPO	☐	☐	☐	☐

MEDICARE/TEFRA INFORMATION

		Effective Date	
Are you eligible for Medicare? Yes ☐ No ☐	Medicare #	Hospital (Part A):	Medical (Part B):
Spouse eligible for Medicare? Yes ☐ No ☐	Medicare #	Hospital (Part A):	Medical (Part B):
Child eligible for Medicare? Yes ☐ No ☐	Medicare #	Hospital (Part A):	Medical (Part B):

INFORMATION ON EMPLOYEE, SPOUSE & CHILDREN (Dependent children eligible up to age 26, regardless of student status)

	Name (Last, First, MI)	Add or Delete	Soc. Sec. Number	M / F	Birth Date	Medical Center or Primary Care Physician	ID #	Current Patient	If Disabled, Date Disability Began
Spouse									
Child					/ /				/ /
Child					/ /				/ /

MEDICAL COVERAGE AUTHORIZATION: (Complete if you ARE enrolling in an HABC medical plan)

I hereby request the above elections for my eligible dependents and myself. I agree to the terms specified in any applicable health benefits certificate or other official description of the terms of my elected plans. I authorize HABC to bill me the amount required to participate in my elected plans. I authorize health care providers to furnish my elected health plans with full information relating to the diagnosis, treatment, or other care rendered to my eligible dependents or me under this membership. Such information will be held confidential. I have carefully read and agree to the terms in this enrollment form and other enrollment information, including the definitions and eligibility provisions for dependents. Enrolled dependents determined to be ineligible shall be terminated and charged for services rendered at the fee-for-service rate less any copayments, coinsurance, deductibles, or premiums paid for said dependents. My statements in this enrollment form are true and complete. I understand that, if I decide at a later date that I want any of the covereages for which my dependents or I are now eligible, but which I have declined, I will have to wait until the next open enrollment period unless I am changing my elections on account of and consistent with a family status change under the provisions of the plan. The elections made here will remain in effect until I complete, and HABC accepts and processes, a new Enrollment/Change Form. THIS IS NOT AN APPLICATION FOR INSURANCE.

Signature: _____ Date: _____

KAISER - PREMIUM RATES FOR ONE ADULT AND MULTIPLE CHILDREN WILL BE THE SAME AS PARENT AND CHILD RATE.

CAREFIRST - PREMIUM RATES FOR ONE ADULT AND MULTIPLE CHILDREN WILL BE THE SAME AS THE FAMILY RATE.