Kent County Retiree Benefit Election Form

Date of Event: 1 / 1 / 25

Effective Date: (H.R. Use Only) ___ / ___ / ___

Privacy No.: (H.R. Use Only) _____

☐ Marriage* ☐ Birth/Adoption* ☐ Medicare Eligible* ☐ Loss of Coverage* ☐ Name/Address Change ☒ Open Enrollment 2025 (year)

☐ Divorce* ☐ Add Dependent(s)* ☐ Delete Dependent(s) ☐ Other _____

*Documentation Necessary

Retiree Social Security No.	Retiree Last Name	Retiree First Name	M.I.	Sex	Birthdate	Phone

Home Address	City	State	Zip	Email

List all dependents below

Check One	Last Name	First Name	M.I.	Sex	Date of Birth	Social Security No.	Relationship
Spouse Add ☐ Delete ☐							
Dep-1 Add ☐ Delete ☐							
Dep-2 Add ☐ Delete ☐							

Non-Medicare Options

Medical Coverage

	BCBS PPO	BCN HMO	Waive Coverage
Retiree	☐	☐	☐
Spouse	☐	☐	☐
Dependent(s)	☐	☐	☐

Prescription Coverage

	Capital Rx	Waive Coverage
Retiree	☐	☐
Spouse	☐	☐
Dependent(s)	☐	☐

New High Deductible Health Plan*

	High Deductible Health Plan	Waive Coverage
Retiree	☐	☐
Spouse	☐	☐
Dependent(s)	☐	☐

*Requires purchase of Capital Rx Coverage.

Vision Coverage

	Vision Service Plan	Waive Coverage
Retiree	☐	☐
Spouse	☐	☐
Dependent(s)	☐	☐

Dental Coverage

	Delta Dental Plan	Waive Coverage
Retiree	☐	☐
Spouse	☐	☐
Dependent(s)	☐	☐

Medicare Plan - Administered by RetireeFirst

Medicare Advantage (Part C)
Priority Health

	Waive
Retiree ☐	☐
Spouse ☐	☐

ALL MEDICARE-ELIGIBLE PARTICIPANTS ARE ASKED TO RETURN A FORM WHETHER ENROLLING IN OR WAIVING COVERAGE IN THE PRIORITY HEALTH MEDICARE ADVANTAGE PLAN.

Other Coverage - Medicare

Are you, your spouse, or dependents Medicare eligible? ☐ yes ☐ no If Yes, please complete Name, Medicare Number and Dates below.

Last Name	First Name	Medicare Number	Part A Effective Date	Part B Effective Date

I understand that the above benefit elections may only be used for me or my dependents as defined under the plan. My benefit elections will remain in effect for the entire plan year, unless I experience a change in my family status. I also understand that I must notify Human Resources within 30 days of the change in my family status in order to change my benefit elections.

Signature: _____ **Date:** _____

Waiver Coverage I wish to waive my medical and prescription benefits. I understand that I will be unable to enroll in health benefits until the next Open Enrollment period unless I experience a change in my family status. I understand that this waiver will become effective the first of the month following receipt of this form by Human Resources. Should I choose to elect coverage during Open Enrollment, my elections will not become effective until January 1st, the beginning of the next plan year.

Signature: **Date:**

Rev. 10/24

NON-MEDICARE ELIGIBLE - DO NOT RETURN THIS FORM IF YOU HAVE NO CHANGES FOR 2025