

STATE OF DELAWARE OFFICE OF PENSIONS

APPLICATION FOR HEALTH CARE COVERAGE - HIGHMARK SPECIAL MEDICFILL (Medicare Supplement)

A. PERSONAL:							
☐ Male ☐ Retiree ☐ Dependen	Pension ID OR SSN:			Agency:			
Female Spouse	OFFICE OF PENSIONS						
Last Name:	First Name:	Date of Birth	Phone	Number:	Alternate F	Phone Number:	
Last Name.	That ivalle.	Date of Birtin	. Thone	rumoer.	Atternate 1	none rumber.	
Address:		<u> </u>	Cit	y: Sta	ate:	Zip Code:	
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B. REASON FOR APPLICATION:							
	ation/Refusal of coverage			S			
Change coverage *You must complete section A and sign below.							
☐ Information change ☐ Double State Share Eligible Effective Date of Coverage: 01/01/2026							
C. HEALTH CARE COVERAGE CHOICE	CS:						
MEDICARE SUPPLEMENT COVERAGE CHOICE: MEDICARE INFORMATION: Must enroll if eligible							
☐ Highmark Special Medicfill with prescription Plea			Please include copy of Medicare card with this application.				
Ingiliarik Special Wedierini wi	Medicare #:						
☐ Highmark Special Medicfill wi	Part A Effecti	Medicare #: Part B Effective Date:					
		T dit 71 Elleeti	ve Bate	Turt B	Effective B	- tate:	
D. OTHER COVERAGE INFORMATION		1.1	.1				
Are you covered by If YES	Is this coverage ntage Plan? Are you covered by another Part D qualified prescription plan?						
		1 1	ption plan?	ian?			
YNY	□N □Y	□N					
E. TERMS OF AGREEMENT:							
I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employe association and Highmark Delaware. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete.							
3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark Delaware with the understanding that payment wi not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available t							
not be complete until actually received. 4) I, o them concerning any diagnosis treatment or o	n behalf of myself and my covere ther health care services they reno	d dependents, authorized	e any physician, l d dependents its	hospital or any other health	care provider to	release information available to this contract 5) I on behalf o	
myself and my covered dependents, authorize	Highmark Delaware to release an	propriate demographic	information, diag	pnostic and medical condition	ons to other pers	sons, entities or organizations fo	
audits, claims processing, coordination of ber and assurance and other reasonably related pur	efits, disease management progra	ams, member satisfactions is contract or as require	on surveys, other d by law.	r party liability, utilization	review, case ma	nagement, quality improvement	
I <u>ELECT</u> to participate in the State Health Insurance and agree to the above terms. This is a <u>binding election</u> . I <u>REFUSE</u> to participate in the State Health Insurance.							
X	X		\mathbf{X}			X	
SIGNATURE	DAT	<u> </u>	_	SIGNATUE	RE	DATE	

RETURN THIS FORM TO: Office of Pensions, 860 Silver Lake Blvd., Suite 1, Dover, DE 19904 or FAX 302-739-6129 EMAIL: Pension.Forms@delaware.gov