

Transitioning to LTD?
Follow this checklist to keep things on track

Included in this Packet:

- Letter from your employing agency – *Disability Insurance Program (DIP) Transition from Short-Term Disability (STD) to Long-Term Disability (LTD)*.
 - **Complete and sign** this letter if you wish to escrow your available leave balances
 - **Time Sensitive** – Must be received by your HR Department before LTD begins
- Long Term Disability Booklet
- Correspondence from the Office of Pensions that includes important information regarding continued eligibility for medical, dental and/or vision benefits as an LTD beneficiary through the State of Delaware
- Open Enrollment Booklet
- Securian GUL Waiver of Premium Information Sheet
- Forms to enroll or refuse medical, dental, vision and or blood bank benefits
 - Office of Pensions Application for Health Care Coverage
 - Complete and sign if you do want medical coverage
 - Office of Pension Health Insurance Coverage REFUSAL
 - Complete and sign if you do not want medical coverage
 - Office of Pensions Dental Application
 - Complete and sign if you do want dental coverage
 - Office of Pensions Dental Insurance Coverage REFUSAL
 - Complete and sign if you do not want dental coverage
 - EyeMed Vision Care Enrollment/Change form
 - Complete and sign if you do want vision coverage
 - Vision Insurance Coverage REFUSAL
 - Complete and sign if you do not want vision coverage
 - Application or Waiver for Membership in the Blood Bank of Delaware Group Plan
 - Complete and sign the top part of the form if you want to enroll in Blood Bank
 - Complete and sign the bottom part of the form if you do not want to enroll in Blood Bank
 - Spousal Coordination of Benefits Policy Form for Pensioners
 - Complete and sign if you cover your spouse

- Adult Dependent Coordination of Benefits Form
 - Complete and sign if you cover an adult child ages 21-26

All completed forms to enroll or refuse medical, dental, vision or blood bank benefits must be mailed to the Office of Pensions as soon as possible to avoid difficulties with your benefits.

Please mail/fax them to: Office of Pensions
 McArdle Bldg
 860 Silver Lake Blvd, Ste 1
 Dover, DE 19904-2402
 Fax: 302-739-6129

If you have any questions regarding your transition from STD to LTD, please call your HR Department at _____.

If you have any questions regarding your medical, dental, vision or blood bank benefits, please the Office of Pensions at 302-739-4208 or 1-800-722-7300.



LIFE INSURANCE FOR DISABLED EMPLOYEES PREMIUM WAIVER BENEFIT

The State of Delaware's Group Universal Life (GUL) insurance program includes an important feature to protect disabled employees. If you become totally disabled while enrolled in the GUL program, the State will continue to pay your (employee only) life insurance premium for as long as you are deemed totally disabled or until you attain age 65, whichever occurs first. As a "premium waiver beneficiary", your GUL coverage will not be reduced by 50% upon employment separation however your Accidental Death and Dismemberment (AD&D) coverage will terminate upon the commencement of the premium waiver benefit. If applicable, you may continue funding the cash accumulation account by paying additional premium payments yourself directly to Securian. Also, if you want to continue any spouse and/or child dependent Term life insurance you have in force during active employment, you must contact Securian directly within 31 days to convert those coverage(s) to an individual policy.

Eligibility

In order to be eligible for this benefit, you must be enrolled in the GUL program for at least one year prior to becoming totally disabled. If you become totally disabled after this one-year period and are approved for the premium waiver benefit by Securian, the State of Delaware will begin to pay your premiums after the exhaustion of the elimination period or when you are approved for the benefit, whichever is later. Once you have been approved, you will be asked from time to time to provide proof that you continue to be totally disabled. If you fail to provide such proof to Securian, your GUL insurance premium will no longer be paid for you by the State of Delaware.

Definition of Total Disability

Employees with a Date of Disability on or after January 1, 2013

"Total disability" or "totally disabled" means that during the 6 month elimination period and subsequent 24 months, you are prevented from performing one or more of the essential duties of your occupation and as a result, your current monthly earnings are less than 80% of your pre-disability earnings; after those 30 months, you are prevented from performing one or more of the essential duties of any occupation for which you are fit through education, experience or training.

Applying for Premium Waiver

Employees enrolled in the Disability Insurance Program (DIP)

Employees awarded Long Term Disability (LTD) benefits by The Hartford who are enrolled in the GUL program will automatically be awarded waiver of premium status by Securian for as long as you are deemed to be totally disabled or until you attain age 65, whichever occurs first. Premium for dependent life coverages, if applicable, must continue to be paid by the employee.

Employees retiring on disability or already retired

Employees, who are retiring on disability or are already retired and are not enrolled in the Disability Insurance Program (DIP), **must apply** for the waiver of premium benefit in the GUL program by completing and submitting a “Notice of Disability” and “Attending Physician Statement” directly to Securian for consideration. The “Notice of Disability” and “Attending Physician Statements” are posted on the Statewide Benefits Office website at www.ben.omb.delaware.gov/life.

Termination or Exhaustion of the Premium Waiver Benefit

If you cease to be totally disabled prior to age 65, or if you fail to give proof of your continued disability when requested by Securian, the State’s payment of your insurance premium will cease, but you may continue your coverage if you promptly resume paying the applicable premium for the coverage according to your date of hire as shown below:

Hired prior to July 1, 2015

Portability – If you leave or retire from a benefit eligible active position, you will be able to port (take with you) 50 percent of your GUL coverage amount and all Dependent Term Life coverage in effect as of your last day of employment. Premiums may be higher than those paid by active employees.

Conversion – You may convert the remaining 50 percent of your GUL coverage amount (based on attained age) into an individual policy, if applied for within 31 days of employment termination or retirement from a benefit eligible position. Dependent Term Life can be converted to individual policies once eligibility expires or upon the approval of premium waiver for the employee.

Hired on or after July 1, 2015

Please note: Applies to employees hired, transferred or rehired into a benefit eligible position as of July 1, 2015.

Portability – If you leave or retire from a benefit eligible active position, you will be able to port (take with you) 100 percent of your GUL coverage amount and all Dependent Term Life coverage in effect as of your last day of employment. Premiums will be higher than those paid by active employees.

Conversion – You can convert 100 percent of your GUL coverage (based on attained age) into an individual policy if applied for within 31 days of employment termination or retirement from a benefit eligible position. Dependent Term Life can be converted to individual policies once eligibility expires or upon the approval of premium waiver for the employee. Converted rates are higher than ported rates.

Summary

Please contact Securian directly by telephone at (877) 215-1489 or by email at lifebenefits@securian.com for more information regarding your coverage. You may also contact the Statewide Benefits Office Customer Service Unit by telephone at (302) 739-8331 or (800) 489-8933 with questions regarding the GUL program.

During the period that you remain totally disabled, you must alert Securian of any change to your address and/or telephone numbers. If you are also enrolled in a life insurance program sponsored by your school district, please contact your district representative for instructions on applying for the waiver of premium benefit, if applicable.

While the State hopes and intends to continue this “premium waiver” feature indefinitely, the State reserves the right at any time, in its sole discretion, to modify or eliminate this feature, without advance notice to employees or disabled employees.



IMPORTANT: Please see reverse side for authorization of healthcare deductions from the Long-Term Disability benefit.

STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR HEALTH CARE COVERAGE

Revised March 2014

LTD

A. REASON FOR APPLICATION

<input type="checkbox"/> New coverage <input type="checkbox"/> Change coverage <input type="checkbox"/> Information change <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Refuse coverage (see Section F)	ADD DEPENDENTS DUE TO: Date of event checked: _____ <input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Non-voluntary coverage loss <input type="checkbox"/> Birth <input type="checkbox"/> Other <input type="checkbox"/> Adoption/Guardianship	CANCEL DEPENDENTS DUE TO: Date of event checked: _____ <input type="checkbox"/> Divorce <input type="checkbox"/> Over age <input type="checkbox"/> No longer dependent	REINSTATE COVERAGE DUE TO: Date of event checked: _____ <input type="checkbox"/> Administrative error <input type="checkbox"/> Other
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B. PERSONAL INFORMATION

<input type="checkbox"/> Male	<input type="checkbox"/> Retiree	<input type="checkbox"/> Non-employee	Date of Retirement (month, day, year)		Social Security Number		Agency or School District	
<input type="checkbox"/> Female	<input type="checkbox"/> Surviving spouse						PENSION OFFICE	
Last Name			First Name		M.I.	Date of Birth (month, day, year)		Home Phone (include area code)
Street Address						City		State Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: Individual Individual & Spouse Individual & child (ren) Family

**Relationship of Spouse applies to Spouse or Civil Union Spouse*

**Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)*

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

- Highmark First State Basic Highmark IPA/HMO Aetna HMO Highmark Comp PPO
 Highmark Consumer Directed Health Gold Aetna Consumer Directed Health Gold

OR

MEDICARE SUPPLEMENT COVERAGE CHOICE:

- Highmark Special Medicfill with prescription Highmark Special Medicfill without prescription

MEDICARE INFORMATION: Must enroll if eligible

Please include copy of Medicare card with this application.

Applicant's Medicare #: _____

Part A Effective Date: _____

Part B Effective Date: _____

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

***If you choose Highmark DE IPA/HMO or Aetna HMO coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents. If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.**

Name of Your Primary Care Physician				Physician's ID Number		Is this your current physician? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.		Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.		Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.		Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.		Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? <input type="checkbox"/> I am <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Blue Cross Blue Shield contract? <input type="checkbox"/> Y <input type="checkbox"/> N
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F. 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 employer, association and Highmark Delaware or Aetna. 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 or Aetna, with the understanding that payment will 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 to them concerning any diagnosis

treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark Delaware or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I **ELECT** to participate in the State Health Insurance and do agree to the above terms.

Signature: _____ Date: _____

I elect **NOT** to participate in the State Health Insurance.

Signature: _____ Date: _____

**REQUEST AND AUTHORIZATION FOR DEDUCTIONS
FROM LONG-TERM DISABILITY BENEFIT**

I am requesting and authorizing The Hartford to withhold full and/or partial current and/or retroactive health care deductions from my Long Term Disability (LTD) benefit for the purpose of paying health care premiums due for my chosen medical, dental and/or vision care coverage through the State of Delaware. Additionally, I acknowledge 1) that while the State of Delaware will establish the initial priority order of deductions should there be insufficient funds to cover all deductions, I may request a change in the priority order of my deductions by contacting the State of Delaware's Office of Pensions and 2) that the State of Delaware may periodically revise the amount of premium/cost and communicate that revised amount to The Hartford. In such event, I authorize The Hartford to deduct that revised amount from any LTD benefit that may be payable to me. Health care deductions will be forwarded to the State of Delaware's Office of Pensions by The Hartford. **In the event my LTD benefit terminates or is interrupted for any reason, I understand that it is my responsibility to contact the State of Delaware's Office of Pensions at (302) 739-4208 or (800)722-7300 immediately to find out what I need to do to continue the required premium payments for my healthcare coverage(s). I understand and agree that The Hartford assumes no liability and expressly disclaims any and all liability which may result from the termination, cancellation, or interruption of any health care coverage paid through the utilization of The Hartford's Benefit Deduction Service.** I further understand and agree that if the State of Delaware's disability policy with The Hartford should terminate and/or if I return to work in any capacity for the State of Delaware or another employer, my health care deductions will cease to be deducted from my Long Term Disability benefit. Should my benefits be insufficient to cover the deductions, I will be billed by the State of Delaware and will be required to pay the cost of insurance directly to the State of Delaware.

Signature

Date

OFFICE OF PENSIONS

HEALTH INSURANCE COVERAGE

REFUSAL

I elect not to participate in a health insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.

Form DR (4/2007) §

LTD

**STATE OF DELAWARE OFFICE OF PENSIONS
DENTAL APPLICATION**

Effective Date

(MM/DD/YY)

IMPORTANT: Please see reverse side for authorization of healthcare deductions from the Long-Term Disability benefit.

Please check the applicable box or boxes.

New Enrollment
 Coverage Change

Name Change
 Address Change

Change of Dependents
 Termination

Please select who coverage is for:

Employee
 Employee & Spouse
 Employee & Child(ren)
 Family

Please select one dental plan of your choice:

Delta Dental #1260-0001
 Dominion Dental #15339-*Must provide Dentist

NOTE: INCOMPLETE INFORMATION ON THIS FORM WILL DELAY YOUR ENROLLMENT. PLEASE PRINT CLEARLY.

Social Security Number		Employee Name (Last, First, Middle Initial)		Date of Birth
Home Address				Home Phone
City	State	Zip Code	Work Phone	
Date of Marriage	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Agency	PENSION OFFICE			

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT

Last Name	First Name	MI	Sex	Date of Birth	Social Security	*Primary Care Dentist Name	*Primary Care Dentist Code
Employee				/ /	- -		
Spouse				/ /	- -		
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped				/ /	- -		
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped				/ /	- -		
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped				/ /	- -		

IMPORTANT: Do you or your dependent(s) have other Group Dental Coverage? YES NO
If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number

Employee's Signature _____ **Date** _____

**REQUEST AND AUTHORIZATION FOR DEDUCTIONS
FROM LONG-TERM DISABILITY BENEFIT**

I am requesting and authorizing The Hartford to withhold full and/or partial current and/or retroactive health care deductions from my Long Term Disability (LTD) benefit for the purpose of paying health care premiums due for my chosen medical, dental and/or vision care coverage through the State of Delaware. Additionally, I acknowledge 1) that while the State of Delaware will establish the initial priority order of deductions should there be insufficient funds to cover all deductions, I may request a change in the priority order of my deductions by contacting the State of Delaware's Office of Pensions and 2) that the State of Delaware may periodically revise the amount of premium/cost and communicate that revised amount to The Hartford. In such event, I authorize The Hartford to deduct that revised amount from any LTD benefit that may be payable to me. Health care deductions will be forwarded to the State of Delaware's Office of Pensions by The Hartford. **In the event my LTD benefit terminates or is interrupted for any reason, I understand that it is my responsibility to contact the State of Delaware's Office of Pensions at (302) 739-4208 or (800)722-7300 immediately to find out what I need to do to continue the required premium payments for my healthcare coverage(s). I understand and agree that The Hartford assumes no liability and expressly disclaims any and all liability which may result from the termination, cancellation, or interruption of any health care coverage paid through the utilization of The Hartford's Benefit Deduction Service.** I further understand and agree that if the State of Delaware's disability policy with The Hartford should terminate and/or if I return to work in any capacity for the State of Delaware or another employer, my health care deductions will cease to be deducted from my Long Term Disability benefit. Should my benefits be insufficient to cover the deductions, I will be billed by the State of Delaware and will be required to pay the cost of insurance directly to the State of Delaware.

Signature

Date

OFFICE OF PENSIONS

DENTAL INSURANCE COVERAGE

REFUSAL

I elect not to participate in a dental insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.



LTD

Enrollment/Change Form

Please print and complete all sections.

See instructions below.

Underwritten by Fidelity Security Life Insurance Company of
Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Effective Date
9812363	State of Delaware	

PENSIONER INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Pensioner ID	Last Name (Pensioner or subscriber)	First Name	M.I.	Date of Birth
Social Security Number	Home Street Address		City/State/Zip		Home Phone ()	

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (pensioner)	First Name	M.I.	Date of Birth
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth

Pensioner Signature: _____ **Date:** _____

Instructions:

Effective date: Beginning date of coverage.

Family Information: List only eligible family members who are enrolling.

Dependent eligibility is the same as employer's health plan.

(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.

(T) Terminate: To terminate enrollment.

(C) Change: A change of Pensioner name, address or phone

The vision plan is a binding election. Once enrolled, you may not drop coverage during the plan year.

Please note: *The enrollment form is for the Pension Office's use only and will not be used for any external purpose.*

IMPORTANT: Please see reverse side for authorization of healthcare deductions from the Long-Term Disability benefit.

**REQUEST AND AUTHORIZATION FOR DEDUCTIONS
FROM LONG-TERM DISABILITY BENEFIT**

I am requesting and authorizing The Hartford to withhold full and/or partial current and/or retroactive health care deductions from my Long Term Disability (LTD) benefit for the purpose of paying health care premiums due for my chosen medical, dental and/or vision care coverage through the State of Delaware. Additionally, I acknowledge 1) that while the State of Delaware will establish the initial priority order of deductions should there be insufficient funds to cover all deductions, I may request a change in the priority order of my deductions by contacting the State of Delaware's Office of Pensions and 2) that the State of Delaware may periodically revise the amount of premium/cost and communicate that revised amount to The Hartford. In such event, I authorize The Hartford to deduct that revised amount from any LTD benefit that may be payable to me. Health care deductions will be forwarded to the State of Delaware's Office of Pensions by The Hartford. **In the event my LTD benefit terminates or is interrupted for any reason, I understand that it is my responsibility to contact the State of Delaware's Office of Pensions at (302) 739-4208 or (800)722-7300 immediately to find out what I need to do to continue the required premium payments for my healthcare coverage(s). I understand and agree that The Hartford assumes no liability and expressly disclaims any and all liability which may result from the termination, cancellation, or interruption of any health care coverage paid through the utilization of The Hartford's Benefit Deduction Service.** I further understand and agree that if the State of Delaware's disability policy with The Hartford should terminate and/or if I return to work in any capacity for the State of Delaware or another employer, my health care deductions will cease to be deducted from my Long Term Disability benefit. Should my benefits be insufficient to cover the deductions, I will be billed by the State of Delaware and will be required to pay the cost of insurance directly to the State of Delaware.

Signature

Date

OFFICE OF PENSIONS

VISION INSURANCE COVERAGE

REFUSAL

I have been advised of the vision plan provided by EyeMed Vision Care.

I elect not to participate in the vision insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.

APPLICATION FOR MEMBERSHIP

Blood Bank of Delmarva Group Plan 

(First) (M.I.) (Last) Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Pension ID Number: _____

Telephone (home): _____ (business): _____

(cell): _____ Date of Birth: ____ / ____ / ____

Name of Spouse/Civil Union Spouse: _____

Your Employer: STATE OF DE - RETIREE

Blood Bank of Delmarva asks everyone to join its NEW Members for Life plan and take a turn providing blood at least once a year and allow the Blood Bank to contact them if there is ever a need for their blood type. Most healthy people between 17 and 79 can give blood. Those age 80+ require medical approval.



Date

Signature

WAIVER FORM

Blood Bank of Delmarva Group Plan 

*I have reviewed the details of the Blood Bank of Delmarva Group Plan and **do not wish** to become a member at this time.*

(First) (M.I.) (Last) Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Pension ID Number: _____

Telephone (home): _____ (business): _____

(cell): _____ Date of Birth: ____ / ____ / ____

Name of Spouse/Civil Union Spouse: _____

Your Employer: STATE OF DE - RETIREE

Date

Signature

Spousal Coordination of Benefits Policy Form for Pensioners



State of Delaware

Check the Box for your Carrier

PLEASE PRINT ALL INFORMATION REQUESTED

Highmark Delaware Aetna

Pensioner's FULL NAME - Last, First, Middle Initial		Pensioner's HOME PHONE - Include area code	
Pensioner's SOCIAL SECURITY NUMBER			
SPOUSE'S FULL NAME - Last, First, Middle Initial	SPOUSE'S SOCIAL SECURITY NUMBER	<input type="checkbox"/> Male <input type="checkbox"/> Female	SPOUSE'S BIRTH DATE / /

SPOUSE INFORMATION Note: If your spouse is retired; references to "Employer" below indicate your spouse's former employer and/or retiree health care coverage.

My spouse is: Not Employed Employed Full-time

Benefit eligible State of Delaware employee Benefit eligible State of Delaware retiree

Employed Part-time with employer coverage Employed Part-time without employer coverage

Self-Employed / Sole Proprietor Partner/Owner/Part Owner of Corporation (See #3 on back of form for more info)

Retired from a non-State employer: Date of Retirement _____

NAME OF SPOUSE'S EMPLOYER OR FORMER EMPLOYER (If spouse is a benefit-eligible State of Delaware employee or pensioner, simply write State of Delaware in this box, leave all following questions blank, and **sign/date** form)

- Does your spouse's employer or former employer offer health care insurance? Yes No
- Is your spouse enrolled in health care coverage through this employer or former employer? Yes No
 - If not enrolled, what percentage of the premium of the lowest benefit employee only/retiree only plan would your spouse be required to pay? _____% **Flexible benefits and credits apply toward employer's contribution.*
- If you indicated your spouse is a business owner or partner:
 - What percentage of the premium is your spouse required to pay? _____%
 - What percentage of the plan cost do the employees pay who do not have ownership interest in the company? _____%
- If your retired spouse declined health care coverage at retirement, does the former employer permit him or her to enroll at the next enrollment period? Yes No
 - If your spouse is permitted to enroll in retiree health care coverage, what is the date of the next enrollment period? _____
- What is the name of your spouse's health insurance carrier? _____
Effective date of your spouse's coverage:
Month: _____ Day: _____ Year: _____
- Is your spouse enrolled in a Health Savings Account (HSA)? Yes No
- Is your spouse enrolled in Medicare? Yes No
- Is your spouse's health plan a Medicare Supplement plan? Yes No
- Does your spouse's employer offer prescription drug coverage as part of a medical plan or as a standalone plan? Yes No
- If you are completing this form due to your spouse's loss of coverage, please indicate the termination date of that coverage.
Date: _____

ADDITIONAL COMMENTS OR EXPLANATION:

STOP! BEFORE SIGNING, PLEASE READ THE AUTHORIZATION SECTION ON THE BACK OF THIS FORM.

YOUR SIGNATURE BELOW VERIFIES THAT YOU HAVE READ AND UNDERSTAND ALL INFORMATION INCLUDED IN THE AUTHORIZATION SECTION.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT AND I HAVE READ THE AUTHORIZATION SECTION:

Pensioner's Signature: _____ Date: ____ / ____ / _____

AUTHORIZATION

Please read carefully the information below before signing. You are responsible for understanding the requirements of the Spousal Coordination of Benefits Policy described here, for providing verification as requested, and for the accuracy of the information in this form.

- I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers and spouses who are retired and are eligible for medical coverage through their former employers:
 1. This information will be shared with the State of Delaware's plan administrator(s).
 2. If spouses do not enroll in their own employers' (or former employers') medical coverage, the State will reduce payment to 20% of covered services provided by the retiree's State of Delaware benefit plan, and amounts not paid will be the sole responsibility of the retiree and spouse.
 3. Spouses who are partners, owners or part-owners of a corporation or company that requires a contribution of less than 50% of the premium for the lowest benefit employee-only plan available must also enroll in that coverage. If they do not do so, the State will reduce payment to 20% of covered services provided by the employee's State of Delaware benefit plan, and amounts not paid will be the sole responsibility of the employee and spouse.
 4. When spouses enroll in their own employer's or former employer's medical coverage, those plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee family benefit plan, not exceeding a limit of 100% coverage from both plans combined.
- I understand that the Coordination of Benefits form must be completed in order to cover my spouse on my State of Delaware Group Health Insurance plan. The form is used to determine a spouse's eligibility to receive primary State of Delaware health benefits. Generally, the following spouses are not required to enroll in their company health benefits and may receive primary State of Delaware health benefits:
 - Spouses not working full time, **or**
 - Spouses who are self-employed/sole proprietors, **or**
 - Spouses who do not yet qualify for coverage through the employer (verification of eligibility date may be required from the employer); **or**
 - Spouses whose employer or former employer require a contribution of more than 50% of the premium for the lowest benefit employee only plan available (verification from the company may be required), **or**
 - Spouses whose employer or former employer does not offer medical coverage (verification from the employer may be required), **or**
 - Spouses who (1) retired before October 1, 2011, (2) declined medical coverage at the time of retirement, and (3) are now not permitted to enroll during the former employer's next Open Enrollment (verification may be required).

If any of this information changes, I must complete a new form within 30 days.

Please go to www.ben.omb.delaware.gov/documents/cob to read the complete Spousal Coordination of Benefits policy and view additional information regarding HSA Accounts.

Notice to all parties completing this form: To insure benefits are coordinated properly between employers, The State of Delaware will verify the accuracy of information by conducting audits, contacting you, and/or contacting your spouse's employer or former employer. It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your spouse. Any claims that paid based on false or incorrect information will be reversed and payment will be the responsibility of the retiree.

Please sign and return the completed form to the Pension Office.

Adult Dependent Coordination of Benefits Form



State of Delaware

PLEASE PRINT ALL INFORMATION REQUESTED

Check Carrier: Blue Cross Aetna

EMPLOYEE FULL NAME - Last, First, Middle Initial		YOUR HOME PHONE - Include area code	
EMPLOYEE SOCIAL SECURITY NUMBER		Check one: This is the first form for my adult dependent <input type="checkbox"/> This is an updated form for my adult dependent <input type="checkbox"/>	
ADULT DEPENDENT'S FULL NAME - Last, First, Middle Initial	ADULT DEPENDENT'S SOCIAL SECURITY NUMBER	<input type="checkbox"/> Male <input type="checkbox"/> Female	DEPENDENT'S BIRTH DATE / /

EMPLOYER INFORMATION

MY ADULT DEPENDENT IS: <input type="checkbox"/> Full-time Student <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Not Employed		
NAME AND ADDRESS OF EMPLOYER		EMPLOYER PHONE NUMBER Include Area Code
Does this employer offer health care insurance to employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your adult dependent enrolled in health care insurance through this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not enrolled, what percentage of the premium of the lowest benefit employee only plan would your adult dependent be required to pay?*
	Is this a High Deductible Plan with a Health Savings Account (HSA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the name of your adult dependent's health care insurance carrier?*	What is the plan policy number? Effective Date:	Annual plan renewal date for this employer: Month: Day:
Does this employer's medical plan cover prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Your additional comments:	
If you are completing this form due to your adult dependent's loss of coverage please indicate the termination date of that coverage. Date:		

AUTHORIZATION

I understand that the following policy applies to adult dependents age 21 to 26 who are eligible for health care coverage through their own employers:

- This information will be shared with the State of Delaware's plan administrator(s).
- If adult dependents over age 21 take advantage of their own employer's health care coverage, these plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's family benefit plan, not exceeding a limit of 100% coverage from both plans combined.
- If adult dependents over age 21 do not take advantage of their own employer's health care coverage, the State will pay 20% of covered services provided by the employee's State of Delaware benefit plan.

I understand this form must also be completed every year during Open Enrollment or any time my adult dependent's employment or coverage situation changes in order to cover my adult dependent under the State of Delaware Group Health Insurance plan. The form is used to determine eligibility to receive primary State of Delaware health benefits. Generally, the following adult dependents over age 21 are not required to enroll in their employers' plans:

- Adult dependents who are full-time students under age 24, or
- Adult dependents who are not working full time, or
- Adult dependents whose employer does not offer health care coverage, or
- Adult dependents whose employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available.

If any of this information changes, I must complete a new form within 30 days and submit to my agency benefits representative.

Notice to all parties completing this form: To insure benefits are coordinated properly between employers, the State of Delaware will verify the accuracy of information by conducting audits, contacting you, and contacting your adult dependent's employer. It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your adult dependent. Any claims paid based on false or incorrect information will be reversed and payment will be the responsibility of the employee.

Please return completed form to your organization's Human Resources or Benefits Representative.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT	Date: / /
Member's Signature	

A complete copy of the State of Delaware's Policy can be found online at www.ben.omb.delaware.gov/documents/cob