Anne Arundel County Public Library

Retiree Open Enrollment Health Benefits Form – 2025 Plan Year

Name: _____ SS #: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Gender: _____ Daytime Phone #: _____ Email Address:_____

Instructions: Use this form to make changes to your benefit elections for the 2025 calendar year. Return the completed form to AACPL Human Resources, 5 Harry Truman Parkway, Annapolis, MD 21401 by October 31, 2024. **No response is necessary if you are not making any changes. If you do not send in a change form, your current elections will be retained.**

Health Care Election- Enter coverage election(s) for 2025 calendar year

Medical Plans	**Medical Plan Coverage Level**
❒ Aetna Open Choice PPO ❒ Open Access Aetna Select HMO-EPO ❒ AETNA PPO Extended Service Area (ESA) (**Attach copy of Medicare Card**) ❒ No Coverage**	❒ Individual ❒ Retiree & 1 Child ❒ Retiree & Spouse ❒ Family ❒ Split Option: Retiree's Plan Name _____ Retiree's Spouse Plan Name: _____
Dental Plans	**Dental Plan Coverage Level**
❒ Cigna PPO Dental (Core) ❒ Cigna PPO Dental (Buy-Up) ❒ CIGNA Dental Care (***DHMO Network Dentist Required***) ❒ No Coverage**	❒ Individual ❒ Retiree & 1 Child ❒ Retiree & Spouse ❒ Family
Vision Plan	**Vision Plan Coverage Level**
❒ EyeMed Vision ❒ No Coverage**	❒ Individual ❒ Retiree & 1 Child ❒ Retiree & Spouse ❒ Family

Other Health Coverage? Check here ❒ if you or your dependents are covered by another insurance policy

In the section below, list all eligible individuals for whom coverage is requested.
Attach copy of Marriage or Birth Certificate if you are adding dependents who were not covered in 2024.

Full Name	Relationship	Social Security Number	Gender	Birth Date
	SELF			

By signing below, I request enrollment as indicated above and agree to pay any premiums required to participate in the selected plans.
I certify that any person for whom I am electing coverage meets the applicable requirements for spouse or dependent coverage under the Plan and I agree to inform the Benefits Office if that changes while my election of coverage is in effect. I understand that I may change my elections only during Open Enrollment, for coverage effective the next January 1, or by requesting a permitted change within 31 days of a family status change. I attest that the information provided above is complete and true to the best of my knowledge. I understand that false information will result in claim denial and possible termination of eligibility for coverage.

Retiree Signature: _____ **Date**: _____

****Return the completed form to Human Resources 5 Harry Truman Parkway, Annapolis, MD 21401 by October 31, 2024.**

This form can be mailed, sent via Fax to 410-222-7188, or emailed to humanresources@aacpl.net

For HR Use Only: Effective Date – 1/1/2025

RX:_____ CIGNA:_____ HCBO:_____ Vision:_____