



For Open Enrollment Use Only

Type or print and forward to the Retirement Health Insurance Unit.
Please refer to carecompass.ct.gov for your annual Health Care Options Planner for more information.

1 Your Personal Information

Form with fields: Retiree/Survivor Last Name, First Name, MI, Retirement Date, Employee Number, Street Address, City, State, Zip Code, Social Security Number, Date of Birth, Gender, Home Telephone Number, Email Address, Cell/Mobile Telephone Number.

2 Application Type

Form with fields: Annual Open Enrollment, Enrollment Change: Select which changes you are making (Medical Plan, Dental Plan, Dependent Change).

3 Choose Non-Medicare Medical Plan Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records.

Form with checkboxes: Primary Care Access [POE-G Plus], Standard Access [POE], Quality First Select Access [Prime Plus/Tiered POS], Expanded Access [POS], Anthem State Preferred POS - Currently Enrolled Only, Anthem Out of Area Plan - Only if Retiree's Permanent Residence is Outside of Connecticut, Waive Medical Coverage.

4 Choose Your Dental Plan

Form with checkboxes: Basic Dental Plan, Enhanced Dental Plan, Total Care DHMO Plan, Dental HMO Plan - Currently Enrolled Only, Waive Dental Coverage.

5 Spouse/Dependent Information

List all of your dependents to be enrolled or dropped in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

Table with 8 columns: Name, Relationship, Gender, Date of Birth, Social Security Number, Medical (Add, Drop), Dental (Add, Drop).

6 Signature and Authorization

Form with text: I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services may be subject to exclusions, limitations, and conditions described by the health plan. I certify that all information on this form is correct to the best of my knowledge and belief. I understand that providing false and/or incomplete information may result in the loss of coverage and/or nonpayment of claims for me or my eligible dependent(s). It is my responsibility to notify the Office of the State Comptroller when a dependent becomes ineligible. I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check and/or bill me as necessary for the medical and/or dental insurance indicated above.
Retiree/Survivor Signature, Date

Please complete this form and email to osc.rethealth@ct.gov

