

RETIREE HEALTH ENROLLMENT/CHANGE FORM

CO-744 REV.10/2023



State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
Retirement Health Insurance Unit
165 Capitol Ave.
Hartford, CT 06106-1775
www.osc.ct.gov

Type or print and forward to the Retirement Health Insurance Unit.

You must submit a completed enrollment application and any required documentation to the Retirement Health Insurance Unit **within 31 days** of your initial benefits eligibility date or **within 31 days** of a qualified change in family status. Please refer to <https://carecompass.ct.gov> for your annual Health Care Options Planner for more information.

① Your Personal Information

Retiree/Survivor Last Name		First Name, MI		Retirement Date		Employee Number (From Active Employment)	
Street Address (no P.O. boxes)				City		State	Zip Code
Social Security Number		Date of Birth (MM/DD/YYYY)	Gender	Home Telephone Number			
Email Address				Cell/Mobile Telephone Number			

② Application Type

<input type="checkbox"/> New Retirement Enrollment <input checked="" type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Adding/Dropping Dependents		Qualifying Status Change: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Change in Dependent Eligibility Status		Date of Event: ____/____/_____ <input type="checkbox"/> Start of Other Coverage <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Death of Spouse/Dependent	
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③ Your Medicare Information

Complete this section if you are eligible for Medicare and would like to enroll in state-sponsored medical and prescription coverage. If you are not yet eligible for Medicare, leave this section blank.

Medicare Claim Number (as it appears on your card)	Medicare Part A Effective Date (MM/DD/YYYY)	Medicare Part B Effective Date (MM/DD/YYYY)	End Stage Renal Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No
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④ 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.

<input type="checkbox"/> Primary Care Access [POE-G Plus]	<input type="checkbox"/> Expanded Access [POS]	<input type="checkbox"/> Waive Medical Coverage
<input type="checkbox"/> Standard Access [POE]	<input type="checkbox"/> Anthem State Preferred POS – Currently Enrolled Only	
<input type="checkbox"/> Quality First Select Access [Prime Plus/Tiered POS]	<input type="checkbox"/> Anthem Out of Area Plan – Only if Retiree's Permanent Residence is Outside of Connecticut	

⑤ Choose Your Dental Plan

Basic Dental Plan
 Enhanced Dental Plan
 Total Care DHMO Plan
 Dental HMO Plan
 Waive Dental Coverage

⑥ 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.

Name	Relationship	Gender	Date of Birth	Social Security Number	Medical		Dental	
					Add	Drop	Add	Drop
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

⑦ Dependent Medicare Information

List all Medicare eligible dependents, attach additional sheet if necessary. If no dependents are eligible for Medicare, leave this section blank.

Name	Medicare Claim Number (as it appears on Medicare card)	Medicare Part A Effective Date (MM/DD/YYYY)	Medicare Part B Effective Date (MM/DD/YYYY)	End Stage Renal Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No
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⑧ Signature & Authorization

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
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CO-744 HEALTH BENEFITS