2026 FCG Retiree Health Benefit Enrollment

IMPORTANT: All Medicare-eligible participants must enroll in the CareFirst BCBS Group Advantage (PPO) Plan.
If you or your spouse are eligible for Medicare, please complete the CareFirst Enrollment Form
or contact Retiree First at (301) 685-3471 to assit with your enrollment.

ENROLLMENT TYPE

☐ New Enrollment
☐ Mid-Year Enrollment Change
☐ Open Enrollment Change
☐ Cancel Coverage

MEDICAL PLAN ENROLLMENT (Med)	DENTAL PLAN ENROLLMENT (Den)	VISION PLAN ENROLLMENT (Vis)
☐ Cigna OAP In-Network Plan ***(Non-Medicare Eligible Plan)***	☐ Cigna Basic PPO Dental Plan	☐ VSP Vision Plan
☐ Cigna High Deductible Plan ***(Non-Medicare Eligible Plan)***	☐ Cigna Enhanced PPO Dental	
CareFirst BCBS Group Advantage (PPO) **Complete CareFirst Enrollment Form**	☐ Cigna Dental HMO	

RETIREE INFORMATION

Social Security Number	Retirement Date		Effective Date/Change Date	
Last Name	**First Name**	**MI**	**Date of Birth**	**Gender**

Street Address (**Residential address required if electing Cigna TrueChoice Medicare (PPO)*)	City	State	Zip

Primary Phone Number	Email Address	Marital Status
		☐ Married ☐ Single

DEPENDENT INFORMATION (You may only include a spouse and/or dependent(s) who were enrolled at the time of retirement)

Action	Last Name	First Name	MI	Sex	Birthdate	Relationship**	Plan Enrollment
☐ Enroll ☐ Cancel						Spouse	☐ Cigna OAP In-Network Plan ☐ Cigna High Deductible Plan CareFirst BCBS Group Advantage (PPO) **Complete CareFirst Enrollment Form**
	Select Benefit(s) ☐ Med | ☐ Den | ☐ Vis	Social Security Number:					
☐ Enroll ☐ Cancel						Child	**Disabled Child?** ☐ Yes ☐ No
	☐ Med | ☐ Den | ☐ Vis	Social Security Number:					
☐ Enroll ☐ Cancel						Child	☐ Yes ☐ No
	☐ Med | ☐ Den | ☐ Vis	Social Security Number:					
☐ Enroll ☐ Cancel						Child	☐ Yes ☐ No
	☐ Med | ☐ Den | ☐ Vis	Social Security Number:					

**For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible retiree, please provide address on separate sheet.

CONDITIONS OF ENROLLMENT

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY OR ANY OTHER PERSON. PENALTIES INCLUDE INPRISONMENT AND/OR FINES. IN ADDITION, THE INSURANCE COMPANY MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the benefit plan that I have selected may provide reimbursement for certain benefit related costs, which are more fully described in the current Benefits Summary and Certificates of Coverage. I understand there may be instances where treatment decisions made by my health care provider or me, or health care expenses which I have incurred, may not be covered by my benefit plan(s).

Employee Signature: _____ Date: _____

Effective November 2024

Return To: Frederick County Government
Attn: Human Resources
12 E Church Street
Frederick, MD 21701

Fax No. (301) 600-2314

Email (Preferred) Retirement@FrederickCountyMD.gov