Broward Sheriff's Office Retiree Aetna CHANGE or CANCEL

Return completed Form to BSO Employee Benefits: Fax 954-321-4530 *-OR-* Email: BSO_RetireeBenefits@sheriff.org

Mail: Broward Sheriff's Office Attn: HR/Employee Benefits

2601 W Broward Blvd, Ft. Lauderdale, FL 33312

RETIREE INFORMATION	❒ *"X" if this is a NEW Address*		
Required Last Name	Required First Name	M.I.	CCN
Required Street Address	Required City and State		Zip Code
Required Social Security	Required Contact Telephone	Date of Retirement	***Effective Date***

PLAN CHANGE

"X" the Aetna Plan to be CHANGED or CANCELLED

***MEDICARE**

*Copy of Medicare Card REQUIRED

✕	Aetna Plans	Single	Family	Single - 1 Medicare	Family - 1 Medicare	Family - 2 Medicare
❒	**HNOnly-1**	❒	❒	❒	❒	❒
❒	**HNOnly-2**	❒	❒	❒	❒	❒
❒	**HNOption**	❒	❒	❒	❒	❒
❒	**OAMC**	❒	❒	❒	❒	❒

CANCEL Retiree Group Health

1. You have 30 days from the last date of coverage to rescind the cancellation IN WRITING

2. You are NOT eligible to re-enroll in BSO Group Health Insurance Plan once coverage is cancelled

Signature

Date

Retiree and/or DEPENDENT INFORMATION: Required to add, change or delete dependents

Required Add / Change / Delete	Required Last Name	Required First Name	Required Gender	Required Date of Birth	Required Social Security Number
✕	Retiree - Required		❒M ❒F	Required	Required
❒Add ❒Change ❒Delete	***Spouse*** - If adding, requires proof of relationship		❒M ❒F	Required	Required
❒Add ❒Change ❒Delete	***Domestic Partner*** - If adding, requires proof of relationship		❒M ❒F	Required	Required
❒Add ❒Change ❒Delete	Child - If adding, requires proof of relationship		❒M ❒F	Required	Required
❒Add ❒Change ❒Delete	Child - If adding, requires proof of relationship		❒M ❒F	Required	Required
❒Add ❒Change ❒Delete	Child - If adding, requires proof of relationship		❒M ❒F	Required	Required

Dependent children eligible to age 26. Coverage terminates December 31st of the year they turn 26.

Proof of Relationship - Marriage Certificate OR Domestic Partner Certificate, Birth Certificate for Dependent Children

Required Retiree Signature		**Required** Date

To be COMPLETED by Employee Benefits (PLEASE PRINT numbers CLEARLY) ***Revised 09/2017***

✕	Aetna Plan	Tier Fam/Single	Medicare 0, 1, or 2	Single Retiree %	Single Retiree $	Single BSO $	Family Retiree %	Family Retiree $	Family BSO $
❒	HNOnly-1								
❒	HNOnly-2								
❒	HNOption								
❒	OAMC								

Benefits Representative: CCN: Date:

❒ ***Address Change*** ❒ ***Medicare Change***

To: tkervin@aetna.com

Cc: tcornman@aetna.com; lxvaldesthom@aetna.com; rxrobertelli@aetna.com; dkshaver@aetna.com; elizabeth_parker@sheriff.org; carolle_stremy@sheriff.org