

STATE OF MARYLAND

ACTIVE & SATELLITE EMPLOYEES HEALTH BENEFITS ENROLLMENT AND CHANGE FORM FOR JANUARY 2015-DECEMBER 2015

PERSONAL DATA *PLEASE PRINT CLEARLY*

Name: _____
LAST FIRST MI

Address: _____ Apt/Condo: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) ____ - ____

Work Phone: (____) ____ - ____

Cell Phone: (____) ____ - ____

Personal E-mail: _____

Work E-mail: _____

Social Security Number: ____ / ____ / ____

Date of Birth: ____ / ____ / ____
MM / DD / YYYY

Sex: Male Female
Legal Marital Status: Single Married Widowed
Limited Divorce/Legally Separated Divorced

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

Work full-time or 50% or more of the normal week: Pay Center
Central Payroll

Work ____ hrs. per week University
Satellite: _____

Agency Code: _____ Check Dist. Code: _____
(if applicable)

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

New Employee Entry on Duty Date: _____

Return from leave of absence/LAW Date: _____

Open Enrollment - Effective January 1st

Employee ineligible (e.g., change to part-time less than 50%)

Cancel all Coverage in all Plans/Reason: _____

Change in Family Status (See Benefits Guide for documentation requirements)

Note: Request must be made within 60 days of the date of the qualifying event.

Add dependent because of:

Marriage Date: _____

Birth/Adoption/Appointed Permanent Legal Guardian Date: _____

Other Reason: _____

Remove dependent because of:

Divorce/Limited Divorce/Legal Separation Date: _____

Death Date: _____ (Attach copy of Death Certificate)

Dependent no longer eligible Date: _____

Reason: _____

Other Change: _____

Note on Retroactive Adjustments:

Employees must contact their Agency Benefits Coordinator within 60 days to file a Retroactive Adjustment to backdate coverage to your Entry on Duty date, or in the case of a status change, the date of the event. Newborn enrollment is required to be backdated to date of birth through the Retroactive Adjustment form.

COMPLETED AND SIGNED ENROLLMENT FORMS MUST BE GIVEN TO YOUR AGENCY BENEFITS COORDINATOR

If you are enrolling dependents outside of Open Enrollment,
all required dependent documentation must be attached.

Health benefits information and forms are available on our website:

www.dbm.maryland.gov/benefits

EBD Use Only:
____ Reviewed
____ Processed
____ Audited

ENROLLMENT FOR JANUARY 2015-DECEMBER 2015

DEPENDENT INFORMATION *PLEASE PRINT*

Dependent means your eligible: (a) spouse, or (b) dependent child(ren) (including biological child, adopted child, stepchild, grandchild, step grandchild, legal ward). See Benefits Guide for a complete listing of eligible dependents and the dependent documentation requirements.

Please provide your dependent information below. **PLEASE PRINT. THIS FORM MUST BE FILLED OUT COMPLETELY (INCLUDING SOCIAL SECURITY NUMBER AND DATE OF BIRTH) TO ENSURE YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECT.** Please use this section for additions (A), deletions (D) or changes (C) to your existing dependent information for Open Enrollment or a qualifying event.

A D C	LAST NAME	FIRST NAME, MI	SEX	DATE OF BIRTH MM/DD/YYYY	RELATIONSHIP	SOCIAL SECURITY NO.	(✓) COVER THIS DEPENDENT FOR:		
							MEDICAL	DRUG	DENTAL

Special Notifications:

- Tax-qualified dependent children age 26 and over must have become disabled prior to reaching age 26 in order to be eligible for continued coverage.
- Grandchildren and Legal Wards age 25 are not eligible for tax-favored coverage and you may owe increased taxes if the State subsidizes dependent coverage for individuals who are not your tax dependents. Refer to the Benefits Guide for details.

ENROLLMENT FOR JANUARY 2015-DECEMBER 2015

Medical Benefits

CHOOSE ONE OPTION:

New Enrollment
Change in plan
Addition or removal of dependent
No, I do not want to enroll in this benefit
Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:

Employee Only
Employee & One Child
Employee & Spouse
Employee & Family
End Stage Renal (ESRD)
(Complete Medicare Information below)

CHOOSE ONE MEDICAL PLAN:

CareFirst BC/BS EPO
CareFirst BC/BS PPO
Kaiser IHM*
UnitedHealthcare EPO
UnitedHealthcare PPO

Bargaining Unit I members only (SLEOLA):

CareFirst BC/BS EPO Mod-I
CareFirst BC/BS POS Mod-I
CareFirst BC/BS PPO Mod-I

**Employees and/or dependents with Medicare due to End Stage Renal Disease (ESRD) are not eligible to enroll in the Kaiser medical plan.*

If you or a dependent have Medicare, write in name, Medicare number, and effective date of Medicare coverage.

NAMES OF INDIVIDUALS WITH MEDICARE	MEDICARE NUMBER (with suffix)	PART A (Hospital Claims) Effective Date MM/DD/YYYY	PART B (Medical Claims) Effective Date MM/DD/YYYY	PART D (Prescription Drug) Effective Date MM/DD/YYYY	MEDICARE DUE TO (✓):		
					Age 65	Disabled	ESRD
Employee							
Spouse							
Child							
Child							

NOTE: Vision and Mental Health/Substance Abuse benefits are included if enrolled in a medical plan.

Medical plans do not include Prescription Drug or Dental coverage. Separate selections are required.

Prescription Drug Coverage

CHOOSE ONE OPTION:

New enrollment
Addition or removal of dependent
No, I do not want to enroll in this benefit
Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:

Employee Only
Employee & One Child
Employee & Spouse
Employee & Family

Dental Coverage

CHOOSE ONE OPTION:

New enrollment
Change in plan
Addition or removal of dependent
No, I do not want to enroll in this benefit
Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:

Employee Only
Employee & One Child
Employee & Spouse
Employee & Family

CHOOSE ONE DENTAL PLAN:

United Concordia DPPO
Delta Dental DHMO

For the DHMO Plan: You must select a primary Dentist office once enrolled. Call plan or see plan website for details.

Accidental Death and Dismemberment Benefits

CHOOSE ONE OPTION:

New enrollment
Change of benefit amount
Addition or removal of dependent
No, I do not want to enroll in this benefit
Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:

Employee Only coverage
Family coverage

CHOOSE ONE BENEFIT AMOUNT:

\$100,000
\$200,000
\$300,000

Flexible Spending Accounts – SELECTED AMOUNTS ARE PER PAY CHECK

YOU MUST COMPLETE THIS SECTION IF YOU WANT TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT FROM JANUARY 2015-DECEMBER 2015.

HEALTHCARE

CHOOSE ONE OPTION:

Enroll in Healthcare Spending Account
Change in Healthcare Spending Account
No, I do not want to enroll in this benefit
Cancel Healthcare Spending Account

\$.

Write in dollar amount to be deducted from each paycheck

DAY CARE

CHOOSE ONE OPTION:

Enroll in Dependent Day Care Spending Account
Change in Dependent Day Care Spending Account
No, I do not want to enroll in this benefit
Cancel Dependent Day Care Spending Account

\$.

Write in dollar amount to be deducted from each paycheck

If you will be retiring before January 1, 2016, only expenses incurred prior to retirement can be considered for reimbursement.

See Benefits Guide for Minimum/Maximum deduction amounts. Check with your Agency Benefits Coordinator for your number of deductions.

Reminder: This is not a yearly deduction amount. THIS IS THE AMOUNT DEDUCTED PER PAY PERIOD FOR JANUARY 2015-DECEMBER 2015.

Life Insurance Plan

OPTIONS-Choose only one

Choose a Coverage Amount in increments of \$10,000 up to \$300,000:

Fill in the amount of Benefit

\$ **0**,

SECTION 2: SPOUSE INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. **You cannot select an amount for your dependents greater than 50% of the amount selected for yourself.**

OPTIONS-Choose only one

Having selected Life Insurance for myself, I wish to have Life Insurance on my spouse.

I currently have Life Insurance for my spouse and am making a change.

No, I do not want Life Insurance on my spouse.

Cancel Life Insurance on my spouse.

Choose a Coverage Amount in increments of \$5,000 up to 1/2 of the amount chosen for yourself, up to \$150,000:

STOP-If you choose an amount greater than \$25,000, you must fill out a Life Insurance Evidence of Insurability for your spouse. The life insurance vendor will contact you about completing this form. Amount over \$25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

\$,

SECTION 3: CHILD(REN) INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. **You cannot select an amount for your dependents greater than 50% of the amount selected for yourself.**

OPTIONS-Choose only one

Having selected Life Insurance for myself, I wish to have Life Insurance for my child(ren).
I currently have Life Insurance for my child(ren) and am making a change.
No, I do not want Life Insurance on my child(ren).
Cancel Life Insurance on my child(ren).

Choose a Coverage Amount in increments of \$5,000 up to 1/2 of the amount chosen for yourself, up to \$150,000:

STOP-If you choose an amount greater than \$25,000, you must fill out a Life Insurance Evidence of Insurability for each covered child. The life insurance vendor will contact you about completing this form. Amount over \$25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

\$,

Employee Signature

Please enroll me for the benefits indicated on this form. I understand the benefits and limitations provided by the various plans and I authorize the State of Maryland to make the necessary adjustments in my pay based on the choices I have made. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget and Management (DBM) regulations. The Mandatory Insurer Reporting Law 42 U.S.C. 1395y(b)(7) requires group health plans to report SSNs in order for Medicare to coordinate payments with other insurance benefits. Please refer to our Notice of Privacy Practices in the Benefit Guide and on our website for more detailed information. **I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a change in status permitted by COMAR 17.04.13.04 and IRS Section 125.**

I understand that if I have enrolled in the Healthcare Flexible Spending Account, that I may seek reimbursement for services incurred through March 15, 2016. I also understand that if I am enrolled in one or both of the Flexible Spending Accounts I must file for reimbursement by April 16, 2016 in order to avoid losing my contributions and that my decision to deposit funds in the Spending Accounts is binding through December 31, 2015 and can only be modified if there is a qualifying change in status permitted by Section 125 of the Internal Revenue Code.

I understand that the benefits program offered by the State is subject to modifications and changes and that the benefits I have chosen on this enrollment form are only in effect for JANUARY 2015-DECEMBER 2015. The State of Maryland reserves the right to modify any of the benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond December 31, 2015. **I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for which I or they are enrolled on this form.**

I certify that I and any dependents listed for coverage are eligible for coverage. I understand that enrollment in benefits to which I or my dependents are not entitled is considered fraud. **In all cases I am responsible for the accuracy of my benefits, coverage levels and deductions.** I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my benefits application, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be cancelled. I may be required to repay any claims and insurance premiums which have been paid inappropriately, and I may face criminal investigation and prosecution.

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact the plan's member service department before signing this application. Plan phone numbers are listed on the inside front cover of the Benefits Guide.

Is there any other health insurance coverage in which you, your spouse, or any of your dependents are enrolled? No Yes

Effective Date: ____/____/____

Specify who is covered, name of Insurance Company and Policy Number: _____

I certify that I have discussed a Retroactive Adjustment with my Agency Benefits Coordinator.

X _____ /_____/_____
Employee Signature Date

Agency Signature - Agency Must Sign Here FORMS WILL NOT BE PROCESSED WITHOUT AN AGENCY SIGNATURE

I hereby certify that the person applying for enrollment is employed by the Agency. I certify that I have discussed a Retroactive Adjustment with the employee and have reviewed the form and accompanying documents for accuracy.

X _____ Agency Benefits Coordinator	____/____/_____ Date	(____) _____ Work Phone Number (Ext.)	_____ Department
_____ Agency Benefits Coordinator Email Address	(____) _____ Fax Number		