# STATE OF MARYLAND

## CONTRACTUAL / VARIABLE HOUR EMPLOYEES
## HEALTH BENEFITS ENROLLMENT AND CHANGE FORM FOR JANUARY 2016-DECEMBER 2016

## 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*

**Works 30 hours per week or an average of 130 hours per month:**
○ Yes ○ No

**Pay Center**
- ○ Central Payroll
- ○ University

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

***Please attach completed Checklist and Employee Questionaire***

## STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

○ Contractual/Variable Hour Employee State Subsidy Eligible

Contract Period From:_____ To: _____

○ Contractual/Variable Hour Employee NO State Subsidy

Contract Period From:_____ To: _____

○ Open Enrollment - Effective January 1st

○ 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: _____

## DECLINE ALL COVERAGE

By signing below, I certify that I have been given an opportunity to enroll in coverage for myself and my eligible dependents, if any. I am declining enrollment. I FURTHER CERTIFY THAT I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage. I UNDERSTAND THAT I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for THE OTHER HEALTH INSURANCE OR GROUP HEALTH PLAN coverage, or if the employer stops contributing towards my or my eligible dependents' other coverage.

X _____ ____/____/____ X _____ ____/____/____
Employee Signature Date Agency Benefits Coordinator Signature Date

**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.**

**If eligible, the State subsidy applies only to medical and prescription coverage. Employee pays full premium for all other coverage elected.**

**Health benefits information and forms are available on our website: www.dbm.maryland.gov/benefits**

EBD Use Only:
____ Reviewed
____ Processed
____ Audited

# *ENROLLMENT FOR JANUARY 2016-DECEMBER 2016*

## DEPENDENT INFORMATION *PLEASE PRINT*

Dependent means your eligible: (a) spouse, or (b) dependent child(ren) (including biological child, adopted child, stepchild, grandchild, step grandchild, other child relative, 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* |
| | | | | | | | ☐ | ☐ | ☐ |
| | | | | | | | ☐ | ☐ | ☐ |
| | | | | | | | ☐ | ☐ | ☐ |
| | | | | | | | ☐ | ☐ | ☐ |
| | | | | | | | ☐ | ☐ | ☐ |
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| | | | | | | | ☐ | ☐ | ☐ |
| | | | | | | | ☐ | ☐ | ☐ |

**Special Notifications:**

- Biological, adopted and step children age 26 and over must have become disabled prior to reaching age 26 in order to be eligible for continued coverage.
- Tax qualified grandchildren, step grandchildren, legal wards and other child relatives age 25 and over must have become disabled prior to reaching age 25 in order to be eligible for continued coverage.

# ENROLLMENT FOR JANUARY 2016-DECEMBER 2016

## 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

***Members and/or dependents eligible for Medicare due to age, disability, or 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 <u>are included</u> if enrolled in a medical plan.***
***Medical plans <u>do not include</u> 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

## Life Insurance Plan

### EMPLOYEE

***OPTIONS-Choose only one***
- ○ Yes, I want to enroll as a new enrollee in Life Insurance.
- ○ I am currently enrolled in Life Insurance and making a change.
- ○ No, I do not want Life Insurance for myself.
- ○ Cancel Life Insurance.

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

**STOP-If you choose an amount greater than $50,000, you must fill out a Life Insurance Evidence of Insurability form. The life insurance vendor will contact you about completing this form. Amount over $50,000 will not be effective until we receive approval from our life insurance carrier.**

*Fill in the amount of Benefit*

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***Spouse and Child Life Insurance continued on next page***

# ENROLLMENT FOR JANUARY 2016-DECEMBER 2016

## Life Insurance Plan (continued)

### SPOUSE

**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*

$ ☐ ☐ ☐ , 0 0 0

### CHILDREN

**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*

$ ☐ ☐ ☐ , 0 0 0

## Employee Signature

Please enroll me for the benefits indicated on this form. I understand the benefits and limitations provided by the various plans. 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 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 the current plan year. 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 the end of the current plan year. **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 premiums.** 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.

I further solemnly affirm under the penalties of perjury under applicable state laws that any dependent information I have provided is true and accurate. I understand that willful falsification of information contained in this attestation can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the person identified as my dependent, and the termination of coverage for myself (the employee). I understand that a civil action may be brought against me for any losses, including reasonable attorney fees because of a false statement contained in this attestation, and that other serious consequences may result.

I further attest and agree that if a dependent's status changes and the dependent is no longer eligible, I will notify my Agency Benefit Coordinator or the Employee Benefits Division immediately to remove this dependent from my coverage. I also agree to provide the required documentation as outline in the current plan year's Benefits Guide to substantiate the information I have provided, and affirm that each enrolled dependent is my true tax dependent.

X _____ _____/_____/_____

Employee Signature — Date

**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.**

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

**FISCAL OFFER** – PLEASE PRINT THE FOLLOWING FOR SUBSIDY ELIGIBLE CONTRACTUAL EMPLOYEES:

**Appropriation Code:** __ __ __ **Agency** __ __ __ __ __ **PCA** __ __ __ **TC** __ __ __ __ **R Stars Sub Object**

_____ Fiscal Officer Name & Phone Number

_____ Fiscal Officer Signature

**I hereby certify that the person applying for enrollment is employed by the Agency. I certify that the employee works 30 hours a week or 130 hours a month and is eligible for the State Subsidy for medical and prescription coverage.** I 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