STATE OF MARYLAND

DECLINE ALL COVERAGE FORM FOR JANUARY 2017-DECEMBER 2017

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 ○ Limited Divorce/Legally Separated

○ Married ○ Divorced ○ Widowed

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

○ Active Full-Time Employee
Entry on Duty Date: _____

○ Active Part-Time Employee
Entry on Duty Date: _____

○ Satellite Employee
Entry on Duty Date: _____

○ Contractual/Variable Hour Employee **State Subsidy Eligible**
Contract Period From: _____ To: _____

○ Contractual/Variable Hour Employee **NO State Subsidy**
Contract Period From: _____ To: _____

○ LAW - Personal
Effective Date: _____ End Date: _____

○ LAW - Military
Effective Date: _____ End Date: _____

○ LAW - OJI
Effective Date: _____ End Date: _____

Pay Center: ○ Central Payroll ○ University ○ Satellite

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

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 _____ ____/____/____
Employee Signature Date

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

Work Phone#: (__ __ __) __ __ __ - __ __ __ __

Fax#: (__ __ __) __ __ __ - __ __ __ __

E-mail: _____

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

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

EBD Use Only:
____ Reviewed
____ Processed
____ Audited