

STATE OF MARYLAND OPTIONAL RETIREMENT PROGRAM (ORP)
Instruction Sheet for Completing and Submitting an ORP Retiree Health Benefits Enrollment Packet

Enrollment packets may only be submitted within 60 days of a qualifying event (retirement is a qualifying event) or during an Open Enrollment period. Enrollment packets not received within 60 days after your retirement date cannot be processed, and you will have to wait until the next Open Enrollment period or until you experience another qualifying event to enroll.

Retiree health benefits cannot begin until the month in which you receive your first periodic distribution. With a direct retirement, if your employee coverage in the State Employee and Retiree Health Benefits Program does not provide coverage through the end of the month before retirement, you will have a break in coverage. During this period, you may enroll under the Consolidated Omnibus Budget Reconciliation Act (COBRA) with no State subsidy and a 2% administrative fee. **ORP retirees and their surviving beneficiaries must be receiving periodic distributions from a Maryland ORP account to maintain eligibility for Retiree health benefits. If periodic distributions from the Maryland ORP end, eligibility for health benefits ends also. If Maryland ORP distributions restart, the retiree/beneficiary can re-enroll within 60 days of the restart date or during Open Enrollment by submitting a Retiree Enrollment Form for Health Benefits together with Form 5, Verification of Maryland ORP Retirement.**

Please review the State of Maryland Health Benefits Guide distributed each Open Enrollment period regarding:

► Eligibility and State subsidy for ORP retirees and dependents; ► Medicare requirements for full coverage in a retiree group; ► COBRA; ► qualifying events outside Open Enrollment; ► plan changes that may occur in the new plan year.

The ORP Retiree Health Benefits Enrollment Packet Forms are listed below. Complete the checklist on side 2 of this form and submit it with all of the required forms as one packet to the Employee Benefits Division (EBD).

ORP HEALTH BENEFITS

◇ **Retiree Enrollment Form for Health Benefits** and, if applicable, Dependent Verification Documentation for new or re-enrolled dependents with a break in coverage (*see the annual Health Benefits Guide for dependent documentation for eligible dependents*). Documentation is not required for dependents who have continuous coverage from your active employee coverage to retiree coverage.

ORP SERVICE

Form 1 ◇ **Claim of Maryland ORP Service** – completed by the Enrollee;

Form 2 ◇ **Verification of Maryland ORP Service** – Part A is completed by the Enrollee (one for each institution from which you are claiming ORP service); Part B is completed by a HR/Benefits Representative for each institution and returned to you.*

NON-ORP SERVICE

Form 3 ◇ **Claim of Maryland State Non-ORP Service** – completed by the Enrollee;

Form 4 ◇ **Verification of Maryland State Non-ORP Service** – Part A is completed by the Enrollee (one for each agency/institution from which you are claiming non-ORP service); Part B is completed by a Human Resources/Benefits Representative from each agency or institution and returned to you*.

ORP RETIREMENT

Form 5 ◇ **Verification of Maryland ORP Retirement**: Part A is completed by the Enrollee; Part B is completed by a Representative of the ORP Vendor from which you will receive a periodic distribution and returned to you.*

***NOTE: An Agency Benefits Coordinator at the Maryland institution where you work may assist you in collecting the necessary information and completed forms; all forms must be completed and signed. Note that you are responsible for ensuring that all required original forms are submitted to the EBD on time. Please keep a copy.**

Premium Billing and Payments: After the EBD processes your enrollment packet, a cover letter explaining the payment process will be mailed to the home address you provide in this packet along with monthly payment coupons. You may not skip a coupon payment, and all coupons must be paid at least monthly, beginning with the first coupon provided. Failure to pay a monthly premium within the 30-day grace period may result in the loss of coverage for the remainder of the plan year. Multiple coupon payments may be made in advance, if desired.

Checklist for ORP Retiree Health Benefits Enrollment Packet

Enrollee's Name: _____

Please read the instructions on this checklist carefully to determine which forms must be included in the packet you submit to the Employee Benefits Division. **Place a check mark next to all forms that are attached and write the number of forms in each category along with the name(s) of the applicable agency/institution(s) for each form.**

NOTE: Incomplete packets will not be processed and will be returned to you to be completed and resubmitted.

If you are not currently enrolled in retiree health benefits, but your¹ eligibility for retiree health benefits has already been confirmed by the Employee Benefits Division, submit the forms and documents listed in Box A only.

- A. _____ Checklist for ORP Retiree Health Benefits Enrollment Packet
 _____ Retiree Enrollment Form for Health Benefits
 _____ Dependent Verification Documentation for any new dependents or re-enrolled dependents who had a break in coverage (*see the annual open enrollment Health Benefits Guide for eligible dependents and the required dependent documentation*). Documentation is not required for dependents that you currently cover.
 _____ Verification of Maryland ORP Retirement - Form #5 (confirming continuous receipt of a Periodic Distribution from a current/former Maryland ORP vendor (e.g. AIG-Valic, American Century, Fidelity, ING, and TIAA-CREF))

If your eligibility for retiree health benefits has not yet been confirmed by the Employee Benefits Division, submit the forms and documents listed in Boxes A (above) and B (below).

- B. _____ Claim of Maryland ORP Service – Form #1
 _____ Verification of Maryland ORP Service – Form #2 (one for each institution). Please write the number of institutions for which forms are attached: _____
- | Name of Maryland Institution(s) of Higher Education: | Number of Pages per Institution: |
|--|----------------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

If your eligibility for retiree health benefits has not yet been confirmed by the Employee Benefits Division and you are claiming non-ORP service with the State of Maryland in addition to your ORP service, submit the forms and documents listed in Boxes A, B and C (below).

NOTE: If you are **not** claiming any Maryland State service **other than ORP service** (including non-ORP service with a Maryland State institution of higher education, please indicate this by signing the applicable statement in Box C. You do not have to submit the forms listed in Box C if you are claiming only ORP service.

- C.
- I am not claiming any Maryland State service other than ORP service.**
- | | |
|--|------|
| Employee/Retiree/Beneficiary Signature | Date |
|--|------|
- _____ Claim of Maryland State Non-ORP Service – Form #3 (including non-ORP service with a Maryland State institution of higher education)
 _____ Verification of Maryland State Non-ORP Service – Form #4 (one for each Maryland State agency or institution). Please write the number of Maryland State agencies or institutions for which forms are attached: _____
- | Name of Maryland Agency/Institution(s): | Number of Pages per Institution: |
|---|----------------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

¹ If you are the surviving sole primary beneficiary of an ORP retiree, the word “your” means the ORP retiree.

STATE OF MARYLAND OPTIONAL RETIREMENT PROGRAM (ORP)
STATE EMPLOYEE AND RETIREE HEALTH & WELFARE BENEFITS PROGRAM

CLAIM OF MARYLAND ORP SERVICE

Employment History while a Maryland ORP Participant¹

This form should be completed by the Employee, Retiree, or Surviving Eligible Dependent Beneficiary who is enrolling in health benefits. (Please print clearly.) *If your eligibility for health benefits as an ORP Retiree or Beneficiary has already been confirmed by the Employee Benefits Division, you do not have to complete this form.*

ENROLLEE'S PERSONAL DATA:

Name: Dr.() Mr.() Mrs.() Ms.() _____

Last First Middle Initial

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____ Retirement Date²: ____/____/____
MM DD YYYY MM DD YYYY

I began/will begin receiving a periodic distribution under the State of Maryland ORP on: ____/____/____
MM DD YYYY

(Do not include lump sum payments, supplemental retirement accounts, or non-Maryland ORP accounts.)

If you are the Surviving Eligible Dependent Beneficiary of an ORP Employee, please check here ().

If you are the Surviving Eligible Dependent Beneficiary of an ORP Retiree, please check here ().

Name of Employee/Retiree: _____ SS# _____ - _____ - _____ Date of Death: ____/____/____
MM DD YYYY

EMPLOYMENT HISTORY while a MARYLAND ORP PARTICIPANT:

List all of the Maryland institutions of higher education where you³ worked while enrolled in the State of Maryland ORP and the approximate dates of service below, as well as the approximate dates for any unpaid leaves of absence. ***Do not include contractual/contingent non-regular, temporary, grad assistant, or voluntary service or any service while a participant in the Maryland State Retirement/Pension System (MSRPS).*** Maryland institutions of higher education include the institutions of the University System of Maryland, Baltimore City Community College, Morgan State University, St. Mary's College, and the Maryland Higher Education Commission. ***If continued on side 2, please check here ().***

Name of Maryland State Institution of Higher Education Write the complete name of the institution or "unpaid leave of absence" below; for the University System of Maryland, include the complete name and location (i.e., University of Maryland College Park, University of Maryland Baltimore)	Approximate Start Date	Approximate End Date

By my signature below, I solemnly affirm under the penalties of perjury and upon personal knowledge that the information provided by me on this form is true and complete.

Signature

Date

¹ All of the requested information about employment history with the State of Maryland and retirement refers to the ORP retiree.

² If you are the beneficiary of an ORP retiree, "Retirement Date" means that of the ORP retiree.

³ If you are the beneficiary of an ORP retiree, the word "you" means the ORP retiree.

CLAIM OF MARYLAND ORP SERVICE

Employment History while a Maryland ORP Participant¹

Enrollee's Name: Dr.() Mr.() Mrs.() Ms.() _____ - _____
Last First M.I. Soc. Sec. #

MARYLAND ORP EMPLOYMENT HISTORY *(continued from side 1)*. ***If more lines are needed, please make copies of this page and write the number of additional pages here: _____***

Name of Maryland State Institution of Higher Education Write the complete name of the institution or "unpaid leave of absence" below; for the University System of Maryland, include the complete name and location (i.e., University of Maryland College Park, University of Maryland Baltimore)	Approximate Start Date	Approximate End Date

By my signature below, I solemnly affirm under the penalties of perjury and upon personal knowledge that the information provided by me on this form is true and complete.

Signature

Date

¹ All of the requested information about employment history with the State of Maryland and retirement refers to the ORP retiree.

STATE OF MARYLAND OPTIONAL RETIREMENT PROGRAM (ORP)
STATE EMPLOYEE AND RETIREE HEALTH & WELFARE BENEFITS PROGRAM

VERIFICATION OF MARYLAND ORP SERVICE
Employment History while a Maryland ORP Participant¹

A.) Part A should be completed by the Employee, Retiree, or Surviving Eligible Dependent Beneficiary who is enrolling in health benefits. (Please print clearly.) *If your eligibility for health benefits has already been confirmed by the Employee Benefits Division, you do not have to complete this form.*

Name: Dr.() Mr.() Mrs.() Ms.() _____
Last First Middle Initial

Address: _____

Daytime Telephone Number: _____ Social Security Number: _____ - _____ - _____

If you are the Surviving Eligible Dependent Beneficiary of an ORP Employee, please check here ().
If you are the Surviving Eligible Dependent Beneficiary of an ORP Retiree, please check here ().

Name of Employee/Retiree: _____ SS# _____ - _____ - _____ Date of Death: ____/____/____
MM DD YYYY

Please use a separate copy of this form for each Maryland institution from which you are claiming ORP participation. Give this form to the Human Resources/Benefits Representative for the Maryland institution of higher education written below, from which you are claiming ORP participation. *(For the University System of Maryland, include the complete name and location as listed on Form 1 (i.e., University of Maryland College Park, University of Maryland Baltimore).*

Name of Maryland institution of higher education: _____

The original completed form will be returned to you at the address you provided above. *If you would like a copy of the completed form returned to an Agency Benefits Coordinator or someone else who is assisting you with this process, please provide that information below.*

Please send a copy of this completed form to: _____

B.) Part B should be completed by an HR/Benefits representative of the institution. (Please print clearly.)

The individual named above is retired/considering retiring from a Maryland ORP and has claimed employment and Maryland ORP participation with your institution. ***Please complete the chart on the reverse side of this form with the information required to determine this individual's eligibility and State subsidy for retiree health benefits.***

Do not include contractual/contingent non-regular, temporary, grad assistant, or voluntary service or periods of time when the employee was on an unpaid leave of absence or was not an ORP participant.

Name of State institution: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

Name and Title of institution HR/Benefits Representative: _____

¹ All of the requested information about employment history with the State of Maryland and retirement refers to the ORP retiree.

VERIFICATION OF MARYLAND ORP SERVICE

Employment History while a Maryland ORP Participant¹

Enrollee's Name: Dr.() Mr.() Mrs.() Ms.() _____
Last First M.I. Soc. Sec. #

VERIFICATION OF MARYLAND ORP EMPLOYMENT as defined on side 1. Please use a separate line for each time period in which percentage of employment changed. *If more lines are needed, please make copies of this page and write the number of additional pages here:* _____

Name of Maryland institution: _____

In the chart below, only list dates of employment during which contributions were made to the Maryland ORP.

Transaction Dates Affecting % of Employment		Percentage of Employment	
Start Date	End Date	Full-time (100%) ²	Part-time (List %)

By my signature below, I attest that the information provided on this form is true and complete to the best of my knowledge and belief.

 Name of Institution HR/Benefits Representative Signature Date

¹ All of the requested information about employment history with the State of Maryland and retirement refers to the ORP retiree.
² For the purposes of this section, working 40 hours a week for the duration of a nine-or-more-month academic year in a position for which a nine-or-more-month academic year is considered to be an entire work year is full-time employment.

STATE OF MARYLAND OPTIONAL RETIREMENT PROGRAM (ORP)
STATE EMPLOYEE AND RETIREE HEALTH & WELFARE BENEFITS PROGRAM

CLAIM OF MARYLAND STATE NON-ORP SERVICE

Employment History with a Maryland State Agency/Institution **other than ORP Service**¹

This form should be completed by the Employee, Retiree, or Surviving Eligible Dependent Beneficiary enrolling in health benefits. If you did not have any Maryland State service other than ORP service, please sign the statement indicating this on the Checklist (Form 0/Side 2) and you will not have to complete this form. (Please print clearly.) *If your eligibility for health benefits as an ORP Retiree or Beneficiary has already been confirmed by the Employee Benefits Division, you do not have to complete this form.*

ENROLLEE'S PERSONAL DATA:

Name: Dr.() Mr.() Mrs.() Ms.() _____
Last
First
Middle Initial

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____ Retirement Date²: ____/____/____
MM DD YYYY
MM DD YYYY

If you are the Surviving Eligible Dependent Beneficiary of an ORP Employee, please check here ().
If you are the Surviving Eligible Dependent Beneficiary of an ORP Retiree, please check here ().

Name of Employee/Retiree: _____ SS# _____ - _____ - _____ Date of Death: ____/____/____
MM DD YYYY

STATE OF MARYLAND EMPLOYMENT HISTORY other than ORP Service:

Please check (✓) one of the following options:

I am claiming service with the State of Maryland other than ORP service.

() **I currently receive**, () **I am vested to receive**, or () **I will not receive** a monthly Maryland State Retirement and Pension System (MSRPS) retirement benefit as the result of any or all of the employment listed below. If you were eligible to participate in the MSRPS but did not enroll or if you transferred your creditable service earned while an MSRPS participant to another retirement system, please report the employment as a State employee for those periods with a note. This service may or may not impact your eligibility and State subsidy for health benefits.

Please list all of the Maryland State Agencies/Institutions where you³ worked and the approximate dates of employment in the chart below, including employment with Maryland institutions of higher education, other than ORP service. **Do not include contractual or temporary service. If continued on side 2, please check here ().**

Name of Maryland State Agency/Institution <small>Please be specific for agencies/institutions with more than one location (i.e., University of Maryland Baltimore, Baltimore County Department of Social Services)</small>	Approximate Start Date	Approximate End Date

By my signature below, I solemnly affirm under the penalties of perjury and upon personal knowledge that the information provided by me on this form is true and complete.

Signature

Date

¹ All of the requested information about employment history with the State of Maryland and retirement refers to the ORP retiree.

² If you are the beneficiary of an ORP retiree, "Retirement Date" means that of the ORP retiree.

³ If you are the beneficiary of an ORP retiree, the word "you" means the ORP retiree.

STATE OF MARYLAND OPTIONAL RETIREMENT PROGRAM (ORP) RETIREE
STATE OF MARYLAND EMPLOYEE AND RETIREE HEALTH & WELFARE BENEFITS PROGRAM

VERIFICATION OF MARYLAND STATE NON-ORP SERVICE

Maryland State Service other than ORP Service¹

A.) Part A should be completed by the Employee, Retiree, or Surviving Eligible Dependent Beneficiary who is enrolling in health benefits. (Please print clearly.) *If your eligibility for health benefits has already been confirmed by the Employee Benefits Division, you do not have to complete this form.*

Name: Dr.() Mr.() Mrs.() Ms.() _____
Last First Middle Initial

Address: _____

Daytime Telephone Number: _____ Social Security Number: _____ - _____ - _____

If you are the Surviving Eligible Dependent Beneficiary of an ORP Employee, please check here ().

If you are the Surviving Eligible Dependent Beneficiary of an ORP Retiree, please check here ().

Name of Employee/Retiree: _____ SS# _____ - _____ - _____ Date of Death: ____/____/____
MM DD YYYY

Please use a separate copy of this form for each agency/institution from which you are claiming non-ORP service. Give this form to the Human Resources/Benefits Representative for the Maryland State agency/institution from which you are claiming service other than ORP service, including non-ORP service with a Maryland institution of higher education. *Please be specific for agencies/institutions with more than one location (i.e., University of Maryland Baltimore, Baltimore County Department of Social Services).*

Name of Maryland State agency/institution: _____

The original completed form will be returned to you at the address you provided above. *If you would like a copy of the completed form returned to an Agency Benefits Coordinator or someone else who is assisting you with this process, please provide that information below.*

Please send a copy of this completed form to: _____

B.) Part B should be completed by an HR/Benefits representative of the agency/institution (Please print clearly.)

The individual named above is retired/considering retirement from a Maryland Optional Retirement Program and has claimed prior non-ORP service as an employee of the State with your agency/institution (this includes non-ORP service with a Maryland institution of higher education). ***Please complete the chart on the reverse side of this form with the information required to determine this individual's eligibility and State subsidy for retiree health benefits. Do not include contractual, temporary, voluntary or ORP service; only service in a permanent position or service for which retirement credit was purchased should be reported.***

Name of Maryland State Agency/Institution: _____

Agency/Institution Address: _____

Telephone: _____ Fax: _____ Email: _____

Name and Title of Agency HR/Benefits Representative: _____

ORP Form 4/Side 1 (revised 9/2009)

¹ All of the requested information about employment history with the State of Maryland and retirement refers to the ORP retiree.

STATE OF MARYLAND OPTIONAL RETIREMENT PROGRAM
STATE EMPLOYEE AND RETIREE HEALTH & WELFARE BENEFITS PROGRAM

VERIFICATION OF MARYLAND ORP RETIREMENT

ORP Vendor Verification

A.) Part A should be completed by the Employee, Retiree, or Surviving Eligible Dependent Beneficiary enrolling in health benefits. (Please print clearly.) *Complete this form if your eligibility for health benefits as an ORP retiree or beneficiary has not yet been confirmed by the Employee Benefits Division, or if you have had a break in your health benefits coverage. (If the Employee Benefits Division has confirmed your eligibility for health benefits as an ORP retiree/beneficiary who is receiving a lifetime/dual lifetime annuity, you do not have to complete this form, regardless of any breaks in your health benefits coverage.)*

Name: Dr.() Mr.() Mrs.() Ms.() _____
Last Name First Name Middle Initial

Address: _____

Daytime Telephone Number: _____ Social Security Number: _____ - _____ - _____

I am: () an Active Employee who plans to retire on: ____/____/____;
MM DD YYYY

() a Former Employee who plans to retire on: ____/____/____;
MM DD YYYY

() an ORP Retiree; date of retirement: ____/____/____;
MM DD YYYY

() a Surviving Eligible Dependent Beneficiary of an ORP participating Employee;

Name of Employee: _____ SS# _____ - _____ - _____ Date of Death: ____/____/____
MM DD YYYY

() Surviving Eligible Dependent Beneficiary of an ORP Retiree;

Name of Retiree: _____ SS# _____ - _____ - _____ Date of Death: ____/____/____
MM DD YYYY

() None of the above

Please use a separate copy of this form for each ORP vendor from which you will receive a periodic distribution from a Maryland ORP account. Give this form to the representative for the ORP vendor written below:

Name of ORP vendor: _____

The original completed form will be returned to you at the address you provided above. *If you would like a copy of the completed form returned to an Agency Benefits Coordinator or someone else who is assisting you with this process, please provide that information below.*

Please send a copy of this completed form to: _____

Part B should be completed by a representative of the ORP vendor. Please continue on the reverse side.

VERIFICATION OF MARYLAND ORP RETIREMENT

ORP Vendor Verification

Name: Dr.() Mr.() Mrs.() Ms.() _____

Last Name

First Name

Middle Initial

Address: _____

Daytime Telephone Number: _____ Social Security Number: _____ - _____ - _____

PART B.) Part B should be completed by an ORP vendor representative.

1.) Does/will this individual receive a periodic distribution under the State of Maryland ORP? (Do not include lump sum payments, supplemental retirement accounts, or non-Maryland ORP distributions.)

() **Yes**, under the State of Maryland Optional Retirement Program, this individual receives/will receive a _____ distribution that began/will begin in ____/____ for the following:
(frequency of payments) MM YYYY

() single lifetime annuity (*periodic distributions will end upon the retiree's death*);

() dual lifetime annuity;

Name of Beneficiary	Social Security Number	Relationship	Frequency (i.e., monthly)
() lifetime periodic distribution (<i>lifetime expectancy</i>);			
() periodic distribution with a final payment scheduled for ____/____.			

MM YYYY

() **No**, this individual has not requested a periodic distribution from the State of Maryland ORP at this time.

() **No**, this individual is not eligible for a periodic distribution under the State of Maryland ORP at this time.

Name of ORP Vendor: _____

Address: _____

Name and Title of ORP Vendor Representative: _____

Telephone: _____ Fax: _____ Email: _____

By my signature below, I attest that the information provided on this form is true and complete to the best of my knowledge and belief.

ORP Vendor Representative's Signature

Date