

STATE OF MARYLAND

RETIREE HEALTH BENEFITS ENROLLMENT FORM JULY 2011-JUNE 2012

PERSONAL DATA *PLEASE PRINT CLEARLY*

NAME: _____

SEX: Male Female

ADDRESS: _____

LEGAL MARITAL STATUS:

CITY _____

Single Widowed

STATE _____ ZIP CODE _____

Married Divorced

Limited Divorce/
Legal Separation

Home Phone: (____) ____ - ____

Work Phone: (____) ____ - ____

Cell Phone: (____) ____ - ____

Personal E-mail: _____

Work E-mail: _____

Social Security Number: ____ / ____ / ____

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

MY STATUS:

- Maryland State Retirement System Retiree; or
 Surviving Beneficiary;
relationship: _____
- Optional Retirement Plan (ORP) Retiree
(i.e., TIAA-CREF); or
 Surviving Beneficiary;
relationship: _____
- Satellite Retiree;
(Agency Name: _____); or
 Surviving Beneficiary;
relationship: _____

ENROLLMENT/CHANGE REQUESTED

- New Retiree**; Date: _____
Last Day of State employment: _____
- New Beneficiary** of Deceased Retiree
Name of Deceased: _____
Date Deceased: _____
- Medicare Eligibility**
(Complete Medicare Information Section, page 3)
- Open Enrollment**
- Cancel all Coverage** in all Plans/Explain: _____

- Other/Explain:** _____

Change in Family Status

- Add Dependent** because of:
- Marriage; Date: _____
- Domestic Partnership
- Birth/Adoption/Appointed Permanent Legal Guardian;
Date: _____
- Other; Explain: _____
- Remove Dependent** because of:
- Divorce/Legal Separation/Dissolution of Domestic Partnership;
Date: _____
- Death; Date: _____ (*Attach copy of Death Certificate*)
- Dependent no longer eligible; Date: _____
Explain: _____

COMPLETED AND SIGNED ENROLLMENT FORMS SHOULD BE MAILED, FAXED OR HAND-DELIVERED TO:

Employee Benefits Division
301 W. Preston Street, Room 510
Baltimore, Maryland 21201

Hours of Operations: Monday - Friday 8:30 a.m. - 4:30 p.m.
Phone: 410-767-4775 or 1-800-307-8283 FAX: 410-333-7104

Health Benefits information and forms are available on the Department of Budget and Management's website:
www.dbm.maryland.gov (Click *Health Benefits*)

ENROLLMENT FOR JULY 2011-JUNE 2012

Medical Benefits - A Beneficiary is considered a "Retiree"

Choose One Option:

- New Enrollment or Change in Medical Plan
- Add or remove a dependent
- Change due to Medicare Eligibility
- I do not want Medical Coverage
- Cancel current Medical Coverage

Choose One Coverage Level:

Choose from #1 to #5 if no one covered is eligible for Medicare Parts A & B

- 1. Retiree Only, No Medicare
- 2. Retiree & One Child, No Medicare; name: _____
- 3. Retiree & Spouse, No Medicare
- 4. Retiree & Domestic Partner, No Medicare
- 5. Retiree & Two or More, No Medicare

Choose from #6 to #12 if anyone covered is eligible for Medicare (the Retiree must be one of the individuals covered):

- 6. Retiree Only (with Medicare Parts A & B)
- 7. Two People (only one with Medicare Parts A & B)
- 8. Two People (both with Medicare Parts A & B)
- 9. Three People (only one with Medicare Parts A & B)
- 10. Three People (only two with Medicare Parts A & B)
- 11. Three or More People (all with Medicare Parts A & B)
- 12. Four or More People (at least one, but not all with Medicare Parts A & B)

Choose One Medical Plan:

PPO Plans:

- CareFirst BC/BS PPO
- UnitedHealthcare PPO

POS Plans:

- Aetna POS
- CareFirst BC/BS POS*
- UnitedHealthcare POS

EPO Plans:

- Aetna EPO*
- CareFirst BC/BS EPO
- UnitedHealthcare EPO*

For the plans with an asterisk (): Once enrolled, you must contact the plan to select a Primary Care Physician. Call plan or see plan website for details.*

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.

Medicare Information - A Beneficiary is considered a "Retiree"

Medicare information must be provided for anyone covered under your Retiree group policy who is eligible for Medicare due to age (age 65) or disability (any age). Medicare-eligible individuals who do not carry both Part A (Hospital) and Part B (Medical) will be responsible for paying the amount that Medicare would have paid (approximately 80% of all eligible services). For example, a Medicare-eligible Retiree who incurs a \$100.00 Part B claim and does not carry Part B, will be responsible for paying the amount that Medicare Part B would have covered (approximately \$80.00). Medicare rules for End Stage Renal Disease (ESRD) differ; call the Employee Benefits Division for more information. **NOTE: Medicare Part D (Prescription drug) is voluntary. See the Notice of Creditable Coverage for the State's prescription drug plan in the Benefits Guide.**

NAMES OF INDIVIDUALS WITH MEDICARE	MEDICARE NUMBER	PART A	PART B	PART D	MEDICARE DUE TO (✓):		
		(Hospital Claims) Effective Date	(Medical Claims) Effective Date	(Prescription Drug) Effective Date	Age 65	Disabled	ESRD
<i>Retiree</i>		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
<i>Spouse</i>		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
<i>Domestic Partner</i>		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
<i>Child</i>		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
<i>Child</i>		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			

Prescription Drug Coverage - A Beneficiary is considered a "Retiree"

Choose One Option:

- New enrollment
- Add or Remove a Dependent
- Change due to Medicare Part D
- I do not want Prescription Drug Coverage
- Cancel current Prescription Drug Coverage

Choose One Coverage Level:

- Retiree Only
- Retiree & One Child; name: _____
- Retiree & Spouse
- Retiree & Domestic Partner
- Retiree & Two or More People

Dental Coverage - A Beneficiary is considered a "Retiree"

Choose One Option:

- New enrollment or change in Dental plan
- Add or remove a dependent
- I do not want Dental Coverage
- Cancel current Dental Coverage

Choose One Coverage Level:

- Retiree Only
- Retiree & One Child; name: _____
- Retiree & Spouse
- Retiree & Domestic Partner
- Retiree & Two or More People

Choose One Plan:

- United Concordia DPPO
- United Concordia DHMO

For DHMO Plan: Once enrolled, you must contact the plan to select a primary Dentist office. Call plan or see plan website for details.

ENROLLMENT FOR JULY 2011-JUNE 2012

Life Insurance

Retirees cannot have a break in Life Insurance coverage between employment and retirement, increase the amount of coverage or add new dependents upon or after retirement. Retirees (new or existing) may only continue, decrease or cancel Life Insurance for themselves and their eligible dependents who are enrolled in Life Insurance at the time of retirement. **If you choose to decrease or cancel coverage, you cannot re-enroll or increase coverage in the future.** Surviving Beneficiaries who were enrolled in Dependent Life Insurance under the deceased Retiree may only continue Life Insurance through a conversion policy purchased directly from the plan.

RETIREE

Choose One Option:

- Continue Life Insurance (*No break between Employee and Retiree coverage*)
 Decrease Life Insurance (*You cannot increase in the future*)
 Cancel Life Insurance (*You cannot re-enroll in the future*)

Choose a coverage amount in increments of \$10,000 for yourself (must be equal to or less than current coverage):

Fill in the amount of Benefit

\$ 0 ,

SPOUSE/ DOMESTIC PARTNER

Choose One Option:

- Continue Spouse/Domestic Partner Life Insurance (*No break between Employee and Retiree coverage*)
 Decrease Spouse/Domestic Partner Life Insurance (*You cannot increase in the future*)
 Cancel Spouse/Domestic Partner Life Insurance (*You cannot re-enroll in the future*)

Choose a coverage amount in increments of \$5,000 for your spouse or domestic partner up to 1/2 of the amount chosen for yourself (must be equal to or less than current coverage):

Fill in the amount of Benefit

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CHILDREN

Choose One Option:

- Continue Child Life Insurance benefits (*No break between Employee and Retiree coverage*)
 Decrease Child Life Insurance benefits (*You cannot increase in the future*)
 Cancel Child Life Insurance benefits (*You cannot re-enroll in the future*)

Choose a coverage amount in increments of \$5,000 for your and/or your domestic partner's children up to 1/2 of the amount chosen for yourself (must be equal to or less than current coverage):

Fill in the amount of Benefit

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NOTE: See Benefit Guide for information about automatic reductions in Life Insurance coverage beginning at age 65.

Retiree 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 retirement allowance based on the choices I have made. I agree to make any premium payments necessary if my retirement allowance will not support the necessary deductions. I understand that to the extent the State subsidizes or pays part of the cost of my coverages, there may be tax consequences to me if I cover dependents who are not my tax dependents. 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 to my dependents to the benefit plans. The personal information provided on this enrollment form is complete, accurate, and in accordance with the Department of Budget and Management regulations. **I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a qualifying event in accordance with COMAR 17.04.13.04.**

I understand that the Benefit Program offered by the State is subject to modifications and changes and that the benefits I have chosen in this enrollment are only in effect for July 2011-June 2012. 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 June 30, 2012.

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 may face criminal investigation and prosecution.

I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for any type of duplicate coverage.

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 representative before signing this application. Plan phone numbers are listed on the inside front cover of the Benefits Guide.

Other than Medicare and your State of Maryland benefits, do you, your spouse/domestic partner, or any of your dependents have other health insurance?

Yes No Specify who is covered, name of Insurance Company: _____

Policy Number: _____ and Effective Date: _____

X _____ / ____ / ____

Retiree/Beneficiary Signature

Date