

STATE OF MARYLAND

DIRECT PAY ENROLLMENT FORM JULY 2009-JUNE 2010 HEALTH BENEFITS

PERSONAL DATA PLEASE PRINT CLEARLY

EMPLOYEE'S/RETIREE'S INFORMATION

Name:
Address:
 City _____ State _____ Zip Code _____
 Home Phone: () _____ - _____
 Work/Cell Phone: () _____ - _____
 Social Security Number: _____ / _____ / _____
 Date of Birth: ____/____/____

Sex: Male Female

LEGAL MARITAL STATUS:
 Single Widowed
 Married Divorced
 Limited Divorce/Legal Separation

FORMER DEPENDENT'S INFORMATION (if different from employee's information)

Name:
Address:
 City _____ State _____ Zip Code _____
 Home Phone: () _____ - _____
 Work/Cell Phone: () _____ - _____
 Social Security Number: _____ / _____ / _____
 Date of Birth: ____/____/____

Sex: Male Female

LEGAL MARITAL STATUS:
 Single Widowed
 Married Divorced
 Limited Divorce/Legal Separation

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

STATUS

COBRA Date of Qualifying Event: _____
 Are you on Medicare? Yes No

Contractual – Contract Period: From: _____ To: _____

Part-Time Employee (*Less than 50%*)

LAW-MILITARY (Long Term Leave of Absence – Military)
 Effective Date of LAW-MILITARY: _____
 End Date of LAW-MILITARY: _____

LAW – PERSONAL (Long Term Leave of Absence Without Pay)
 Effective Date of LAW-PERSONAL: _____
 End Date of LAW-PERSONAL: _____
 (*May not exceed 2 years*)

LAW-OJI (Long Term Leave of Absence – On the Job Injury)
 Effective Date of LAW-OJI: _____
 End Date of LAW-OJI: _____
 (*May not exceed 2 years*)

ENROLLMENT/CHANGE ACTION REQUESTED

Open Enrollment

New Enrollment

Cancel All Coverage in All Plans

Change in Family Status (See Benefits Guide for Documentation Requirements)

Add dependent because of:
 Marriage Date: _____
 Domestic Partnership
 Birth/Adoption/Appointed permanent legal guardian
 Date: _____
 Other: _____

Remove dependent because of:
 Divorce/Limited Divorce/Legal Separation/Dissolution of
 Domestic Partnership Date: _____
 Date of Death: _____ (*Attach copy of Death Certificate*)
 Dependent no longer eligible. Explain: _____

 Other: _____

Medical Benefits - Available to COBRA, LAW, Contractual, Part-Time

OPTIONS

New Enrollment or
 Change in Enrollment

Addition or removal of
 dependent

No, I do not want to
 enroll in this benefit

Cancel current coverage

COVERAGE LEVEL

Individual Only

Individual & One Child;
 name: _____

Individual & Spouse

Individual & Domestic Partner

Individual & Two or More

End Stage Renal (ESRD)

MEDICAL PLANS

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*

The plans with an asterick () require a Primary Care Physician once enrolled. See plan website for details.*

NOTE: Vision and Mental Health/Substance Abuse benefits are available if enrolled in a medical plan. Medical plans do not include Prescription Drug or Dental coverage. Separate sections are required.

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

Name _____ Medicare Number _____ Date of Coverage ____/____/____

Name _____ Medicare Number _____ Date of Coverage ____/____/____

ENROLLMENT FOR JULY 2009-JUNE 2010**Prescription Coverage - Available to COBRA, LAW, Contractual, Part-Time****OPTIONS**

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

COVERAGE LEVEL

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

Dental Coverage - Available to COBRA, LAW, Contractual, Part-Time**OPTIONS**

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

COVERAGE LEVEL

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

DENTAL PLANS**Check only one dental plan:**

- 1 United Concordia DPPO
- 2 United Concordia DHMO

For the DHMO Plan: You must select a participating Dentist once enrolled. See plan website for details.

Personal Accident and Dismemberment Benefits - Available to LAW/Contractual/Part-Time Only

(NOT AVAILABLE TO COBRA ENROLLEES)

For Contractual/Part-Time Employees Only:

OPTIONS

- New Enrollment or addition/removal of dependent
- Change of benefit amount - select benefit amount
- No, I do not want to enroll in this benefit
- Cancel current coverage

COVERAGE LEVEL

- Employee Only coverage
- Family coverage

BENEFIT AMOUNT

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

For Employees On LAW (Effective 7/1/2009)

- I want to continue my coverage - select benefit amount
- Cancel my coverage

Flexible Spending Accounts - Health Care - Available to COBRA and LAW Only

***For Employees Who Had Flexible Spending Accounts During Active Status In July 2009-June 2010.**

Domestic partners and the dependent children of domestic partners are not eligible for FSA reimbursement.

THIS IS NOT A PRE-TAX BENEFIT WHILE IN DIRECT PAY STATUS AND FUNDS MUST BE USED BY OCTOBER 15, 2010.

Health Care Spending Account

- I want to continue my Health Care Spending Account in July 2009-June 2010. **Note:** COBRA enrollees will be billed for the same total deduction amount as an active employee plus a 2% fee.
- Cancel my Health Care Spending Account. Expenses incurred prior to the cancellation date may be reimbursed up to the limit of your Health Care FSA.

ENROLLMENT FOR JULY 2009-JUNE 2010**Life Insurance - Available to LAW/Contractual/Part-Time Only****APPLICANT LIFE INSURANCE*****For Contractual/Part-Time Employees Only:**

- Yes, I want to continue my July 2009-June 2010 level of coverage. Select benefit amount.
- Yes, I want to continue my Life Insurance, but at a different coverage level. Select benefit amount.
- Yes, I want to enroll as a new enrollee in Life Insurance. Select benefit amount.
- No, I do not want to enroll in this benefit.
- Cancel all Life Insurance (applicant and dependent).

***For Employees on LAW:**

- I want to continue my Life Insurance at the same \$ value as an active employee. Select benefit amount.
- No, I do not want to enroll in this benefit.
- Cancel all Life Insurance (applicant and dependents).

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 Statement of Health for yourself. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for yourself.

Fill in the amount of Benefit

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Coverage available in increments of \$10,000 only

DEPENDENT LIFE INSURANCE***For Contractual/Part-Time Employees Only:****Life Insurance on Spouse/Domestic Partner**

- Yes, I want to continue my spouse's/domestic partner's Life Insurance at the July 2009-June 2010 level.
- Yes, I want to continue my spouse's/domestic partner's Life Insurance, but at a different amount. Select benefit amount.
- Yes, I want Life Insurance for my spouse/domestic partner. Select benefit amount.
- No, I do not want enroll in this benefit.
- Cancel Life Insurance on my spouse/domestic partner.

Fill in the amount of Benefit

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Spouse/Domestic Partner coverage available (up to 50% of employee's coverage) in increments of \$5,000 only, up to \$150,000.

Life Insurance on Child(ren)

- Yes, I want to continue my child(ren)'s Life Insurance at the July 2009-June 2010 level. Select benefit amount.
- Yes, I want to continue my child(ren)'s Life Insurance, but at a different amount. Select benefit amount.
- Yes, I want Life Insurance on my child(ren). Select benefit amount.
- No, I do not want to enroll in this benefit.
- Cancel Life Insurance on child(ren)

Fill in the amount of Benefit

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Child coverage available (up to 50% of employee's coverage) in increments of \$5,000 only, up to \$150,000.

If you choose an amount greater than \$25,000, you must fill out a Life Insurance Statement of Health for your spouse/domestic partner or child. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for each covered spouse/domestic partner or child.

For Employees on LAW (Effective 7/1/2009-6/30/2010)*Continue Life Insurance on Spouse/Domestic Partner**

- I want to continue Life Insurance on my spouse/domestic partner at the same benefit amount as in active status. (Select benefit amount above.)
- Cancel Life Insurance on my spouse/domestic partner.

Continue Life Insurance for Child(ren)

- I want to continue Life Insurance on my child(ren) at the same benefit amount as in active status. (Select benefit amount above.)
- Cancel Life Insurance on my child(ren).

ENROLLMENT FOR JULY 2009-JUNE 2010

COBRA - Consolidated Omnibus Budget Reconciliation Act and Other Continuation Coverage

You and your eligible dependents may continue health coverage if the loss of coverage is due to one of the following qualifying events:

Mark the event that applies to you:

QUALIFYING EVENT	MAXIMUM PERIOD OF TIME ELIGIBLE FOR CONTINUATION*	QUALIFYING EVENT	MAXIMUM PERIOD OF TIME ELIGIBLE FOR CONTINUATION*
<input type="radio"/> 1. Terminated employee (other than for gross misconduct)	18 months or until eligible for group coverage through another source including Medicare	<input type="radio"/> 6. Spouse of a State employee who has elected Medicare as the only coverage and the spouse is not eligible for Medicare	36 months or until eligible for group coverage through another source including Medicare
<input type="radio"/> 2. Resigned	18 months or until eligible for group coverage through another source including Medicare	<input type="radio"/> 7. Previously dependent child of an employee who is no longer eligible by reason of age, marriage, term of domestic partnership or death of employee	36 months or until eligible for group coverage through another source including Medicare
<input type="radio"/> 3. Laid off employee	18 months or until eligible for group coverage through another source including Medicare	<input type="radio"/> 8. Widowed spouse of a State employee/retiree	36 months or until eligible for group coverage through another source including Medicare
<input type="radio"/> 4. Employee whose hours have been reduced	18 months or until eligible for group coverage through another source including Medicare	<input type="radio"/> 9. Dissolution of domestic partnership with a current State employee/retiree	36 months or until eligible for group coverage through another source including Medicare
<input type="radio"/> 5. Divorce or legally separated spouse of a current State employee/retiree	Indefinitely or at the time of remarriage or until eligible for group coverage through another source including Medicare		

* The period of continuation of coverage is the number of months listed, or until eligible for coverage elsewhere, whichever is less.

LAW - Long Term Leave Without Pay

If the long term LAW is the result of a job-related accident or injury (LAW-OJI), the State will pay the State portion and the individual will continue to pay the Active employee portion. A copy of the first report of injury form must be submitted with this enrollment form. If the long term LAW is due to any other reason, the individual must pay 100 percent of the premium. In either case the employee will be billed directly by the Department of Budget & Management for the amount due.

AGENCY BENEFITS COORDINATOR - PLEASE PRINT THE FOLLOWING:

A. _____ is on Approved Leave
Employee's Name

of Absence-On the Job Injury effective _____
Date

B. Anticipated date of return to work: _____
Date

C. Is this an initial LAW-OJI? Yes No **OR** Is this an extension of a previous Long Term LAW-OJI? Yes No

D. _____
Agency Benefits Coordinator's Name (PRINT) Phone Number

Agency

Agency Address / / Date

Signature of Agency Benefits Coordinator or Appointing Authority

FISCAL OFFICER - PLEASE PRINT THE FOLLOWING:

Appropriation Code:
Agency PCA TC R Stars Sub Object

Fiscal Officer Name & Phone Number Fiscal Officer Signature

ENROLLMENT FOR JULY 2009-JUNE 2010

Applicant and Agency Signatures

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.

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 to my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget & Management regulations. I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as the result of a qualifying change in status permitted by Section 125 of the Internal Revenue Code and COMAR 17.04.13.04.

I understand that the Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen in this enrollment form are only in effect for July 2009-June 2010. The State of Maryland reserves the right to modify any benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond June 30, 2010. **I certify that neither I nor my dependents are covered under another State of Maryland employee's or retiree's membership for any type of duplicate coverage.**

I certify that I and the listed dependents are eligible for coverage under the benefit plan rules. I understand that enrollment in benefits to which I am 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 canceled, I will be required to repay any claims and insurance premiums, I may face charges for dismissal from State service, and I may face criminal investigation and prosecution.

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

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

X _____

Your Signature

_____/_____/_____
Date

- -
Your Work/Cell Phone Number

X _____

AGENCY SIGNATURE - Agency Must Sign Here

_____/_____/_____
Date

- -
Work Phone Number (Ext.)

Agency Code: _____
Department

NOTE: This form must be completed in its entirety and appropriate documentation attached to be processed without delay.

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

**Employee Benefits Division
Direct Pay Unit
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**

Website: www.dbm.maryland.gov (Click *State Employees*, then *Health Benefits*)

NOTE: LAW FORMS MUST BE SIGNED BY THE AGENCY BENEFITS COORDINATOR