# STATE OF MARYLAND

# RETIREE HEALTH BENEFITS ENROLLMENT AND CHANGE FORM
# JANUARY 2018-DECEMBER 2018

## PERSONAL DATA *PLEASE PRINT CLEARLY*

**NAME:** _____
LAST FIRST MI

**SEX:** ○ **Male** ○ **Female**

**ADDRESS:** _____ **APT/CONDO:** _____

**CITY:** _____

**STATE:** _____ **ZIP CODE:** _____

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

**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. Please indicate relationship:_____
- ○ Optional Retirement Plan (ORP) Retiree (i.e., TIAA-CREF) or
  - ○ Surviving Beneficiary. Please indicate relationship:_____
- ○ Satellite Retiree
  Agency Name:_____ or
  - ○ Surviving Beneficiary. Please indicate relationship:_____

## STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

- ○ **New Retiree**
  - Effective Date: _____
  - Last Day of State Employment: _____
  - Disability Retirement? ☐ Yes ☐ No
- ○ **New Beneficiary** of Deceased Retiree
  - Name of Deceased: _____
  - Deceased SSN: _ _ _ /_ _ / _ _ _ _
  - Date of Retiree's Death: _____
- ○ **Medicare Eligibility** *(Complete Medicare Information Section, page 3)*
- ○ **Open Enrollment - Effective January 1st**
- ○ **Cancel all Coverage** in all Plans/Reason: _____
  _____
- ○ **Other** Reason: _____

**Change in Family Status** **(See Benefits Guide for documentation requirements)**
**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:_____

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

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

EBD Use Only:
____ Reviewed
____ Processed
____ Audited

**Hours of Operation: Monday - Friday 8:30 a.m. - 4:30 p.m.**
**Phone: 410-767-4775 or 1-800-307-8283 / Fax: 410-333-5191 / Email: enrollment.ebd@maryland.gov**

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

# *ENROLLMENT FOR JANUARY 2018-DECEMBER 2018*

## 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 NUMBERS, DATE OF BIRTH, AND IF THE DEPENDENT IS ELIGIBLE FOR MEDICARE DUE TO AGE (AGE 65) OR DISABILITY (ANY AGE) TO ENSURE THAT YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECT AND CLAIMS ARE PAID PROPERLY.** 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* | *ELIGIBLE FOR MEDICARE (Y/N)* | *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.
- 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 2018-DECEMBER 2018*

## *Medical Benefits* - A Beneficiary is considered a "Retiree"

**Choose One Option:**

- ○ New Enrollment
- ○ Change in 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 #4 if no one covered is eligible for Medicare Parts A & B***

1. ○ Retiree Only, No Medicare
2. ○ Retiree & One Child, No Medicare
3. ○ Retiree & Spouse, No Medicare
4. ○ Retiree & Two or More, No Medicare

***Choose from #5 to #11 if anyone covered is eligible for Medicare (the Retiree must be one of the individuals covered):***

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

**Choose One Medical Plan:**

- ○ CareFirst BC/BS EPO
- ○ CareFirst BC/BS PPO
- ○ Kaiser IHM*
- ○ UnitedHealthcare EPO
- ○ UnitedHealthcare PPO

***Retirees and/or dependents eligible for Medicare are not eligible to enroll in the Kaiser medical plan.**

***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.***

## *Medicare Information* - A Beneficiary is considered a "Retiree"

**Medicare information must be provided for anyone covered under your Retiree enrollment 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 (Physician) will be responsible for paying the amount that Medicare would have paid (approximately 80% of all eligible services). <u>Medicare rules for End Stage Renal Disease (ESRD) differ; see Benefits Guide for more information.</u>

| *NAMES OF INDIVIDUAL(S) 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* |
| ***Retiree*** | | | | | ☐ | ☐ | ☐ |
| ***Spouse*** | | | | | ☐ | ☐ | ☐ |
| ***Child*** | | | | | ☐ | ☐ | ☐ |

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

**Choose One Option:**

- ○ New enrollment
- ○ Add or Remove a Dependent
- ○ I do not want Prescription Drug Coverage
- ○ Cancel current Prescription Drug Coverage

**Choose One Coverage Level:**

- ○ Retiree Only
- ○ Retiree & One child
- ○ Retiree & Spouse
- ○ Retiree & Two or More People

## *Dental Coverage* - A Beneficiary is considered a "Retiree"

**Choose One Option:**

- ○ New enrollment
- ○ Change in 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
- ○ Retiree & Spouse
- ○ Retiree & Two or More People

**Choose One Plan:**

- ○ United Concordia DPPO
- ○ Delta Dental 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 JANUARY 2018-DECEMBER 2018*

## *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

○ Decrease Life Insurance

○ Cancel Life Insurance

**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 , 0 0 0

### *SPOUSE*

**Choose One Option:**

○ Continue Spouse Life Insurance

○ Decrease Spouse Life Insurance

○ Cancel Spouse Life Insurance

**Choose a coverage amount in increments of $5,000 for your spouse 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*

$ ☐ ☐ ☐ , 0 0 0

### *CHILDREN*

**Choose One Option:**

○ Continue Child Life Insurance benefits

○ Decrease Child Life Insurance benefits

○ Cancel Child Life Insurance benefits

**Choose a coverage amount in increments of $5,000 for your and/or your spouse'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*

$ ☐ ☐ ☐ , 0 0 0

***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 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. 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 qualifying event in accordance with COMAR 17.04.13.04 and IRS Section 125.**

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 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 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 coverage for which I or they are enrolled on this form.**

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 retiree). 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 _____ _____/_____/_____

Retiree/Beneficiary Signature Date

**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.**