STATE OF MARYLAND

CONTRACTUAL / VARIABLE HOUR EMPLOYEES

HEALTH BENEFITS ENROLLMENT AND CHANGE FORM FOR JANUARY 2020-DECEMBER 2020

PERSONAL DATA  PLEASE PRINT CLEARLY

Name: ____________________________________________________________

Address: _________________________________________________________

City: ___________________________ State: ___________________________ Zip Code: ____________

Home Phone: (______) __________-________

Work Phone: (______) __________-________

Cell Phone: (______) __________-________

Personal E-mail: __________________________________________________

Work E-mail: _____________________________________________________

W#: W __ __ __ __ __ __ __ __ __

Date of Birth: ___/___/______

MM/DD/YYYY

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

Agency Code: __________ Check Dist. Code: __________

(if applicable)

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

☐ Contractual/Variable Hour Employee State Subsidy Eligible

Contract Period From: ___________ To: ___________

☐ Contractual/Variable Hour Employee NO State Subsidy

Contract Period From: ___________ To: ___________

☐ Open Enrollment - Effective January 1st

☐ Cancel all Coverage in all Plans/Reason: ___________________________

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

Note: 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: _____________________________

☐ Other Change: _____________________________

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

If you are enrolling dependents outside of Open Enrollment, all required dependent documentation must be attached.

If eligible, the State subsidy applies only to medical and prescription coverage. Employee pays full premium for all other coverage elected.

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

EBD Use Only:  

____ Reviewed  

____ Processed  

____ Audited
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 NUMBER AND DATE OF BIRTH) TO ENSURE YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECT.** Please use this section for additions (A), deletions (D) or changes (C) to your existing dependent information for Open Enrollment or a qualifying event.

<table>
<thead>
<tr>
<th>A</th>
<th>D</th>
<th>C</th>
<th>LAST NAME</th>
<th>FIRST NAME, MI</th>
<th>SEX</th>
<th>DATE OF BIRTH MM/DD/YYYY</th>
<th>RELATIONSHIP</th>
<th>SOCIAL SECURITY NO.</th>
<th>(✓) COVER THIS DEPENDENT FOR:</th>
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<td>MEDICAL</td>
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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 2020-DECEMBER 2020

Medical Benefits

**CHOOSE ONE OPTION:**
- New Enrollment
- Change in plan
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

**CHOOSE ONE COVERAGE LEVEL:**
- Employee Only
- Employee & One Child
- Employee & Spouse
- Employee & Family
- End Stage Renal (ESRD)

**CHOOSE ONE MEDICAL PLAN:**
- CareFirst BC/BS EPO
- CareFirst BC/BS PPO
- Kaiser IHH*
- UnitedHealthcare EPO
- UnitedHealthcare PPO

*Members and/or dependents eligible for Medicare due to age, disability, or End Stage Renal Disease (ESRD) are not eligible to enroll in the Kaiser medical plan.

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

<table>
<thead>
<tr>
<th>NAMES OF INDIVIDUALS WITH MEDICARE</th>
<th>MEDICARE NUMBER (with suffix)</th>
<th>PART A (Hospital Claims) Effective Date MM/DD/YYYY</th>
<th>PART B (Medical Claims) Effective Date MM/DD/YYYY</th>
<th>PART D (Prescription Drug) Effective Date MM/DD/YYYY</th>
<th>MEDICARE DUE TO (‘’):</th>
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<tbody>
<tr>
<td>Employee</td>
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<td>Age 65, Disabled, ESRD</td>
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<td>Spouse</td>
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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.

Prescription Drug Coverage

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

**CHOOSE ONE COVERAGE LEVEL:**
- Employee Only
- Employee & One Child
- Employee & Spouse
- Employee & Family

**CHOOSE ONE DENTAL PLAN:**
- United Concordia DPPO
- Delta Dental DHMO

For the DHMO Plan: You must select a primary Dentist office once enrolled. Call plan or see plan website for details.

Dental Coverage

**CHOOSE ONE OPTION:**
- New enrollment
- Change in plan
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

**CHOOSE ONE COVERAGE LEVEL:**
- Employee Only
- Employee & One Child
- Employee & Spouse
- Employee & Family

Accidental Death and Dismemberment Benefits

**CHOOSE ONE OPTION:**
- New enrollment
- Change of benefit amount
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

**CHOOSE ONE COVERAGE LEVEL:**
- Employee Only coverage
- Family coverage

**CHOOSE ONE BENEFIT AMOUNT:**
- $100,000
- $200,000
- $300,000

Life Insurance Plan

**EMPLOYEE**

Options—Choose only one
- Yes, I want to enroll as a new enrollee in Life Insurance.
- I am currently enrolled in Life Insurance and making a change.
- No, I do not want Life Insurance for myself.
- Cancel Life Insurance.

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 Evidence of Insurability form. The life insurance vendor will contact you about completing this form. Amount over $50,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of benefit:

$□□□□□□□□

Spouse and Child Life Insurance continued on next page
Life Insurance Plan (continued)

SECTION 2: SPOUSE INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. You cannot select an amount for your dependents greater than 50% of the amount selected for yourself.

OPTIONS - Choose only one

○ Having selected Life Insurance for myself, I wish to have Life Insurance on my spouse.

○ I currently have Life Insurance for my spouse and am making a change.

○ No, I do not want Life Insurance on my spouse.

Choose a Coverage Amount in increments of $5,000 up to 1/2 of the amount chosen for yourself, up to $150,000:

STOP - If you choose an amount greater than $25,000, you must fill out a Life Insurance Evidence of Insurability form for your spouse. The life insurance vendor will contact you about completing this form. Amount over $25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

$ ☐ ☐ ☐ 

SECTION 3: CHILD(REN) INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. You cannot select an amount for your dependents greater than 50% of the amount selected for yourself.

OPTIONS - Choose only one

○ Having selected Life Insurance for myself, I wish to have Life Insurance for my child(ren).

○ I currently have Life Insurance for my child(ren) and am making a change.

○ No, I do not want Life Insurance on my child(ren).

Choose a Coverage Amount in increments of $5,000 up to 1/2 of the amount chosen for yourself, up to $150,000:

STOP - If you choose an amount greater than $25,000, you must fill out a Life Insurance Evidence of Insurability form for each covered child. The life insurance vendor will contact you about completing this form. Amount over $25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

$ ☐ ☐ ☐ 

Employee Signature

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 my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget and Management (DBM) 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 change in status permitted by COMAR 17.04.13.04 and IRS Section 125.

I understand that the benefits program offered by the State is subject to modifications and changes and that the benefits I have chosen on this enrollment form are only permitted by COMAR 17.04.13.04 and IRS Section 125.

Agency Signature - Agency Must Sign Here

FORMS WILL NOT BE PROCESSED WITHOUT AN AGENCY SIGNATURE

FISCAL OFFER - PLEASE PRINT THE FOLLOWING FOR SUBSIDY ELIGIBLE CONTRACTUAL EMPLOYEES:

Appropriation Code:  

Agency  PCA  TC  R Stars Sub Object

Fiscal Officer Name & Phone Number

Agency Benefits Coordinator

Fiscal Officer Signature

I hereby certify that the person applying for enrollment is employed by the Agency. I certify that the employee works 30 hours a week or 130 hours a month and is eligible for the State Subsidy for medical and prescription coverage. I have reviewed the form and accompanying documents for accuracy.

Agency Benefits Coordinator Email Address

Agency Benefits Coordinator Date

Work Phone Number (Ext.)

Department

Fax Number