STATE OF MARYLAND
CONTRACTUAL / VARIABLE HOUR EMPLOYEES
HEALTH BENEFITS ENROLLMENT AND CHANGE FORM FOR JANUARY 2023-DECEMBER 2023

PERSONAL DATA  PLEASE PRINT CLEARLY

Name: __________________________________________________________________________
LAST    FIRST       MI

Address: _________________________________________________________________________
Apt/Condo: __________________________

City: __________________________ State: __________________________ Zip Code: ______________

Home Phone: (    )    -    -    -

Work Phone: (    )    -    -    -

Cell Phone: (    )    -    -    -

Personal E-mail: ________________________________________________________________

Work E-mail: _________________________________________________________________

W#: W ____________________________

Date of Birth: ____/____/______

To be completed by agency benefits coordinator

Agency Code: __________  Check Dist. Code: __________ (if applicable)

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

☐ New Hire Date: __________

☐ Job Change Date: __________

☐ 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, 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
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 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</th>
<th>RELATIONSHIP</th>
<th>SOCIAL SECURITY NO.</th>
<th>COVER THIS DEPENDENT FOR:</th>
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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.
- Proof of prior employer-sponsored coverage may be required.
ENROLLMENT FOR JANUARY 2023-DECEMBER 2023

Medical Benefits

Medical plans do not include Prescription Drug or Dental coverage. Separate selections are required (see below).

**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 IHM*
- UnitedHealthcare EPO
- UnitedHealthcare PPO

NOTE: Vision and Mental Health/Substance Abuse benefits are included if enrolled in a medical plan.

*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</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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</table>

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

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

**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.*

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

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Spouse and Child Life Insurance continued on next page
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 for 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.
- Cancel 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 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

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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).
- Cancel 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 for your child(ren). 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 hereby 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. 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 employee). 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 ___________________________ / __________ / __________
Employee Signature Date

NOTE: 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.

Agency Signature - Agency Must Sign Here

I hereby certify that I have reviewed the form and all accompanying documents for accuracy.

X ___________________________ / __________ / __________
Agency Benefits Coordinator Date Work Phone Number (Ext.) Department

Agency Benefits Coordinator Email Address

Agency Benefits Coordinator Fax Number