

# STATE OF MARYLAND

## DIRECT PAY ENROLLMENT FORM

### JULY 2013-DECEMBER 2013 HEALTH BENEFITS

#### PERSONAL DATA *PLEASE PRINT CLEARLY*

##### EMPLOYEE/FORMER EMPLOYEE/RETIREE INFORMATION

Name: \_\_\_\_\_  
LAST FIRST MI

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Personal E-mail: \_\_\_\_\_

Work E-mail: \_\_\_\_\_

Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM /DD/ YYYY

Sex:      Male      **LEGAL MARITAL STATUS:**  
           Female      Single      Widowed  
                          Married      Divorced  
                          Limited Divorce/Legal Separation

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

Name: \_\_\_\_\_  
LAST FIRST MI

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Personal E-mail: \_\_\_\_\_

Work E-mail: \_\_\_\_\_

Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM /DD/ YYYY

Sex:      Male      **LEGAL MARITAL STATUS:**  
           Female      Single      Widowed  
                          Married      Divorced  
                          Limited Divorce/Legal Separation

#### STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

**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)*

Open Enrollment - Effective July 1st

New Enrollment

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: \_\_\_\_\_

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

**Employee Benefits Division**  
**Enrollment 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**

EBD Use Only: <input type="checkbox"/> Reviewed <input type="checkbox"/> Processed <input type="checkbox"/> Audited
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**Health benefits information and forms are available on the Department of Budget and Management's website:**  
**[www.dbm.maryland.gov/benefits](http://www.dbm.maryland.gov/benefits)**



## ENROLLMENT FOR JULY 2013-DECEMBER 2013

### 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*
1. Terminated employee (other than for gross misconduct)	18 months or until eligible for group coverage through another source including Medicare
2. Resigned	18 months or until eligible for group coverage through another source including Medicare
3. Laid off employee	18 months or until eligible for group coverage through another source including Medicare
4. Employee whose hours have been reduced	18 months or until eligible for group coverage through another source including Medicare
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

Mark the event, if different, that applies to your dependent:

QUALIFYING EVENT	MAXIMUM PERIOD OF TIME ELIGIBLE FOR CONTINUATION*
6. Spouse or child of a State employee/retiree who has elected Medicare as the only coverage and the spouse or child is not eligible for Medicare	36 months or until eligible for group coverage through another source including Medicare
7. Previously dependent child of an employee/retiree who is no longer eligible by reason of age or death of employee	36 months or until eligible for group coverage through another source including Medicare
8. Death of a State employee/retiree	36 months 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.

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

**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:**

- Individual Only
- Individual & One Child
- Individual & Spouse
- Individual & Family
- End Stage Renal (ESRD)  
(Complete Medicare Information below)

**CHOOSE ONE MEDICAL PLAN:**

- Aetna EPO\*
- Aetna POS
- CareFirst BC/BS EPO
- CareFirst BC/BS POS\*
- CareFirst BC/BS PPO
- UnitedHealthcare EPO\*
- UnitedHealthcare POS
- UnitedHealthcare PPO

*The plans with an asterisk (\*) require a Primary Care Physician once enrolled. 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.

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

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

### Prescription Drug Coverage - Available to COBRA, LAW, Contractual, Part-Time

**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:**

- Individual Only
- Individual & Spouse
- Individual & One Child
- Individual & Family

### Dental Coverage - Available to COBRA, LAW, Contractual, Part-Time

**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:**

- Individual Only
- Individual & One Child
- Individual & Spouse
- Individual & Family

**CHOOSE ONE DENTAL PLAN:**

- United Concordia DPPO
- United Concordia 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 - Available to LAW/Contractual/Part-Time

**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:**

- Individual Only coverage
- Family coverage

**CHOOSE ONE BENEFIT AMOUNT:**

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

### Flexible Spending Account - Healthcare - Available to COBRA and LAW

**\*For Employees Who Had Flexible Spending Accounts During Active Status In July 2013-December 2013.**

Due to federal regulations, same sex spouses and the dependent children of same sex spouses are not eligible for FSA participation.

**THIS IS NOT A PRE-TAX BENEFIT WHILE IN DIRECT PAY STATUS AND SERVICES MUST BE INCURRED BY MARCH 15, 2014.**

**Healthcare Spending Account**

I want to continue my Healthcare Spending Account for July 2013-December 2013.

**Note:** COBRA enrollees will be billed for the same total deduction amount as an active employee plus a 2% fee on a post-tax basis.

Cancel my Healthcare Spending Account. Expenses incurred prior to the cancellation date may be reimbursed up to the limit of your Healthcare FSA.

# ENROLLMENT FOR JULY 2013-DECEMBER 2013

## Life Insurance - Available to LAW/Contractual/Part-Time

### APPLICANT LIFE INSURANCE

- Yes, I want to enroll as a new enrollee in Life Insurance.
- Yes, I want to continue my July 2013-Dec. 2013 level of coverage.
- Yes, I want to continue my Life Insurance, but at a different amount.
- No, I do not want to enroll in this benefit.
- Cancel all Life Insurance (applicant and dependent).

**Please select a benefit 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. Please go to our website [www.dbm.maryland.gov](http://www.dbm.maryland.gov) to download the Evidence of Insurability form. Amount over \$50,000 will not be effective until we receive approval from our life insurance carrier.**

Fill in the Benefit Amount

\$     ,    Coverage available in increments of \$10,000 only

### DEPENDENT LIFE INSURANCE

**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. Please go to our website [www.dbm.maryland.gov](http://www.dbm.maryland.gov) to download the Evidence of Insurability form for each covered spouse or child. Amount over \$25,000 will not be effective until we receive approval from our life insurance carrier.**

#### Life Insurance on Spouse

- Yes, I want Life Insurance for my spouse.
- Yes, I want to continue my spouse's Life Insurance
- Yes, I want to continue my spouse's Life Insurance, but at a different amount.
- No, I do not want to enroll in this benefit.
- Cancel Life Insurance on my spouse.

Please fill in the Benefit amount: \$     ,

#### Life Insurance on Child(ren)

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

Please fill in the Benefit amount: \$     ,

## LAW - Long Term Leave Without Pay Due to a Job-Related Injury

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 employee 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 employee 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 of Absence-On the Job Injury effective \_\_\_\_\_  
Employee's Name 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

### FISCAL OFFICER - PLEASE PRINT THE FOLLOWING:

Appropriation Code:

Agency PCA TC R Stars Sub Object

Fiscal Officer Name & Phone Number

Fiscal Officer Signature

## 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 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 elections except during an Open Enrollment period or as the result of a qualifying change in family status permitted by 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 on this enrollment form are only in effect for July 2013-December 2013. 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 December 31, 2013. **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 certify that I and any dependents listed for coverage are eligible for coverage. 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 premiums.** 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 or any of your dependents are enrolled?

No Yes

Specify who is covered, name of insurance company and policy number: \_\_\_\_\_

X \_\_\_\_\_ Effective Date \_\_\_\_\_  
YOUR SIGNATURE Date

X \_\_\_\_\_ Date \_\_\_\_\_  
AGENCY SIGNATURE - Agency Must Sign Date

Agency Code: \_\_\_\_\_ Work Phone Number (Ext.) \_\_\_\_\_ Fax Number \_\_\_\_\_

Check Dist. Code: \_\_\_\_\_ Agency Benefit Coordinator Email Address \_\_\_\_\_

**NOTE: CONTRACTUAL, PART-TIME AND LAW FORMS MUST BE SIGNED BY THE AGENCY BENEFITS COORDINATOR**