STATE OF MARYLAND

RETIREE HEALTH BENEFITS ENROLLMENT AND CHANGE FORM
JANUARY 2025-DECEMBER 2025

PERSONAL DATA *PLEASE PRINT CLEARLY*

NAME: _____
LAST FIRST MI

SEX: ○ **Male** ○ **Female**

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

CITY: _____

STATE: _____ **ZIP CODE:** _____

COUNTY: _____

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

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

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

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

Personal E-mail: _____

Work E-mail: _____

W#: W _ _ _ _ _ _ _ _

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 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/Qualifying Event: _____
  _____
- ○ **Other** Reason: _____

Change in Family Status **(See Benefits Guide for documentation requirements)**
Request must be made within 60 days of the qualifying event.

- ○ **Add Dependent** because of:
  - ○ Marriage Date: _____
  - ○ Birth/Adoption/Appointed Permanent Legal Guardian
    Date: _____
  - ○ Other Reason: _____

ALL required dependent documentation must be attached when adding a dependent.

- ○ **Remove Dependent** because of:
  - ○ Divorce/Limited Divorce/Legal Separation/Dissolution of domestic partnership Date: _____
  - ○ Death Date: _____ ***(Attach copy of Death Certificate)***
  - ○ Dependent no longer eligible Date: _____
    Reason: _____

COMPLETED AND SIGNED ENROLLMENT FORMS MAY BE SENT BY EMAIL, REGULAR MAIL OR HAND-DELIVERED TO:

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

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: ebd.mail@maryland.gov

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

ENROLLMENT FOR JANUARY 2025-DECEMBER 2025

DEPENDENT INFORMATION *PLEASE PRINT*

Dependent means your eligible: (a) spouse, (b) domestic partner, (c) dependent child(ren), or (d) domestic partner dependent children. All dependent children include biological, adopted, 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 PRINT CLEARLY your dependent information below and ATTACH ALL REQUIRED DOCUMENTATION. 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 dependent are enrolled in the plans you selected 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*	*DOMESTIC PARTNER DEPENDENT (Y/N)*	*ELIGIBLE FOR MEDICARE (Y/N)*	*SOCIAL SECURITY NO.*	*(✓) COVER THIS DEPENDENT FOR:*		
									MEDICAL	*DRUG*	*DENTAL*

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.
- Some dependents are not eligible for tax-favored coverage and the retiree may owe increased taxes if the State subsidizes dependent coverage. Refer to the Benefits Guide for details.

ENROLLMENT FOR JANUARY 2025-DECEMBER 2025

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 #5 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
5. ○ Retiree & Domestic Partner, No Medicare

Choose from #6 to #12 if anyone covered is eligible for Medicare (the Retiree must be one of the individuals covered):

6. ○ Retiree Only (with Medicare Parts A & B)
7. ○ Two People (only one with Medicare Parts A & B)
8. ○ Two People (both with Medicare Parts A & B)
9. ○ Three People (only one with Medicare Parts A & B)
10. ○ Three People (only two with Medicare Parts A & B)
11. ○ Three or More People (all with Medicare Parts A & B)
12. ○ 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 benefits <u>are included</u> if enrolled in a medical plan.

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

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*	*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							
Domestic Partner							
Child							

Prescription Drug Coverage for non-Medicare enrollees - A Beneficiary is considered a "Retiree"

Medicare-eligible Retirees and/or dependents must enroll in Medicare Part D. See Benefits Guide pages 57-62.

Choose One Option:

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

If Retiree and/or dependents are not Medicare-eligible.
Choose One Coverage Level:

- ○ 1. Retiree Only
- ○ 2. Retiree & One Child
- ○ 3. Retiree & Spouse
- ○ 4. Retiree & Family
- ○ 5. Retiree & Domestic Partner

If Retiree is Medicare-eligible with non-Medicare dependents,
Choose One Coverage Level:

- ○ 6. Spouse only
- ○ 7. Child only
- ○ 8. Spouse & One child
- ○ 9. Domestic Partner only
- ○ 10. Domestic Partner & One child
- ○ 11. Family

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 & Domestic Partner
- ○ 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 2025-DECEMBER 2025

Life Insurance

✻ **Retirees cannot have a break in Life Insurance coverage between employment and retirement. Retirees also cannot 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 that are enrolled. **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: *(Only choose a coverage amount if Decreasing Insurance.)*

○ Continue Life Amount in effect at retirement

✻ ○ Cancel Life Insurance

✻ ○ Decrease Life Insurance ⟶ *Fill in the amount of Benefit* $ — — — , — — —

Choose a coverage amount in increments of $10,000 for yourself (must be less than current coverage):

SPOUSE/ DOMESTIC PARTNER

Choose One Option: *(Only choose a coverage amount if Decreasing Insurance.)*

○ Continue Spouse/Domestic Partner Life Amount in effect at retirement

✻ ○ Cancel Spouse/Domestic Partner Life Insurance

✻ ○ Decrease Spouse/Domestic Partner Life Insurance ⟶ *Fill in the amount of Benefit* $ — — — , — — —

Choose a coverage amount in increments of $5,000 for your spouse up to 1/2 of the amount chosen for yourself (must be less than current coverage):

CHILDREN

Choose One Option: *(Only choose a coverage amount if Decreasing Insurance.)*

○ Continue Child Life Amount in effect at retirement

✻ ○ Cancel Child Life Insurance benefits

✻ ○ Decrease Child Life Insurance benefits ⟶ *Fill in the amount of Benefit* $ — — — , — — —

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 less than current coverage):

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 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, with the exception of a domestic partner or domestic partner's child(ren), 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.