

# STATE OF MARYLAND

## ACTIVE & SATELLITE EMPLOYEES HEALTH BENEFITS ENROLLMENT FORM FOR JULY 2010-JUNE 2011

### PERSONAL DATA *PLEASE PRINT CLEARLY*

Name: \_\_\_\_\_

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

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

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

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

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

Work Email: \_\_\_\_\_

Personal Email: \_\_\_\_\_

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

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Agency Code: \_\_\_\_\_

Check Dist. Code: \_\_\_\_\_  
*(if applicable)*

*PLEASE COMPLETE: (MARK ALL APPROPRIATE CIRCLES)*

I work full-time or 50% or  
more of the normal week:

Pay Center

I am paid:

I am 21/22Pay

Sex:

Legal Marital Status:

Central Payroll

Biweekly

Yes

Male

Single

Limited Divorce/  
Legally Separated

University of MD

Monthly

No

Female

Married

I work \_\_\_\_\_ hrs. per week

Satellite (specify agency: \_\_\_\_\_)

Divorced

Widowed

#### EMPLOYEE STATUS

#### ENROLLMENT/CHANGE ACTION REQUESTED

- New Employee; Entry on duty date: \_\_\_\_\_
- Return from leave of absence/LAW Date: \_\_\_\_\_
- Open Enrollment
- Employee requesting change due to change in family status
- Employee ineligible (e.g., change to part-time less than 50%)

**Note on Retroactive Adjustments:**

**Employees must contact their Agency Benefits Coordinator to file a Retroactive Adjustment to backdate coverage within 60 days of the date of the Change in Status or Entry on Duty. Newborn Retroactive Adjustments are required to be backdated to date of birth.**

- New Enrollment (New employee/return from LAW/Open Enrollment):
- Change in family status (See Benefits Guide for Documentation Requirements)
  - Add dependent because of:
    - Marriage; Date: \_\_\_\_\_
    - Domestic Partnership
    - Birth/Adoption/Appointed Permanent Legal Guardian; Date: \_\_\_\_\_
    - Other: \_\_\_\_\_
  - 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-explain: \_\_\_\_\_
  - Other Change: \_\_\_\_\_
  - Cancel all coverage-explain: \_\_\_\_\_

**Completed and signed enrollment forms must be given to your Agency Benefits Coordinator.**

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

**Please see your Benefits Guide for dependent documentation requirements.**

Health Benefits information and forms are available  
on the Department of Budget and Management's website: [www.dbm.maryland.gov](http://www.dbm.maryland.gov).  
Click **Health Benefits**.



## ENROLLMENT FOR JULY 2010-JUNE 2011

### Medical Benefits

**OPTIONS**

- New Enrollment or change in plan
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

**COVERAGE LEVEL**

- Employee Only
- Employee & One Child; name: \_\_\_\_\_
- Employee & Spouse
- Employee & Domestic Partner
- Employee & Family
- End Stage Renal (ESRD) (Complete Medicare Information below)

**MEDICAL PLANS-Choose only one**

**PPO Plans:**

- CareFirst BC/BS PPO
- UnitedHealthcare PPO

**POS Plans:**

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

**EPO Plans:**

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

*Plans with an asterick (\*) require a Primary Care Physician selection once enrolled. See plan website for details.*

**NOTE: Medicare Part D is voluntary. See the Notice of Creditable Coverage for the State's prescription drug plan in the Benefits Guide.**

NAMES OF INDIVIDUALS WITH MEDICARE	MEDICARE NUMBER	PART A (Hospital Claims) Effective Date	PART B (Medical Claims) Effective Date	PART D (Prescription Drug) Effective Date	MEDICARE DUE TO (✓):		
					Age 65	Disabled	ESRD
Employee							
Spouse							
Domestic Partner							
Child							
Child							

**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 below.**

### Prescription Coverage

**OPTIONS**

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

**COVERAGE LEVEL**

- Employee Only
- Employee & One Child; name: \_\_\_\_\_
- Employee & Spouse
- Employee & Domestic Partner
- Employee & Family

### Dental Coverage

**OPTIONS**

- New enrollment or change in plan
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

**COVERAGE LEVEL**

- Employee Only
- Employee & One Child; name: \_\_\_\_\_
- Employee & Spouse
- Employee & Domestic Partner
- Employee & Family

**DENTAL PLANS**

**Check only one dental plan:**

- United Concordia DPPO
- United Concordia DHMO

*For DHMO plan, you must select a primary Dentist office once enrolled. See plan website for details.*

### Accidental Death and Dismemberment

**OPTIONS**

- New Enrollment or Change of benefit amount
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

**COVERAGE LEVEL**

- Employee Only coverage
- Family coverage

**BENEFIT AMOUNT**

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

### Flexible Spending Accounts – SELECTED AMOUNTS ARE PER PAY CHECK

**YOU MUST COMPLETE THIS SECTION IF YOU WANT TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT IN JULY 2010-JUNE 2011.**

*Domestic partners and the dependent children of domestic partners are not eligible for FSA reimbursement.*

HEALTH CARE

**OPTIONS**

- Enroll in Health Care Spending Account
- Cancel Health Care Spending Account

\$    .

*Write in dollar amount per deduction*

DAY CARE

**OPTIONS**

- Enroll in Dependent Day Care Spending Account
- Cancel Dependent Day Care Spending Account

\$    .

*Write in dollar amount per deduction*

If you will be retiring before July 1, 2011, please be advised that only expenses incurred prior to retirement can be considered for reimbursement. Only expenses for tax-qualified dependents may be reimbursed.

**See Benefits Guide for Minimum/Maximum deduction amounts. Check with your Agency Benefits Coordinator for your number of deductions, i.e., 24, 21 or 19. Reminder: This is not a yearly deduction amount. THIS IS THE AMOUNT PER DEDUCTION IN JULY 2010-JUNE 2011.**

## State Life Insurance Plan

### EMPLOYEE

#### OPTIONS

- Yes, I want to enroll as a new enrollee in Life Insurance. Select benefit amount.
- I am currently enrolled in Life Insurance and making a change. Select benefit amount.
- No, I do not want Life Insurance for myself.
- Cancel Life Insurance.

Choose a Coverage Amount in increments of \$10,000 for yourself, up to \$300,000:

**STOP-**If you choose an amount greater than \$50,000, you must fill out a Life Insurance Statement of Health for yourself. Please go to our website [www.dbm.maryland.gov](http://www.dbm.maryland.gov) to download the Statement of Health form for yourself.

Fill in the amount of Benefit

\$     0,

### SPOUSE/ DOMESTIC PARTNER

#### SECTION 2: SPOUSE/DOMESTIC PARTNER 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. The amount requested for your spouse/domestic partner can be up to 50% of the amount selected for you, the employee.

#### OPTIONS

- Having selected Life Insurance for myself, I wish to have Life Insurance on my spouse/domestic partner. Select benefit amount.
- I currently have Life Insurance for my spouse/domestic partner and am making a change. Select benefit amount.
- No, I do not want Life Insurance on my spouse/domestic partner.
- Cancel Life Insurance on my spouse/domestic partner.

Choose a Coverage Amount in increments of \$5,000 for your spouse/domestic partner-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 Statement of Health for your spouse/domestic partner. Please go to our website [www.dbm.maryland.gov](http://www.dbm.maryland.gov) to download the Statement of Health form for your spouse/domestic partner.

Fill in the amount of Benefit

\$     ,

### CHILDREN

#### SECTION 3: CHILDREN 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. The amount requested for your children can be up to 50% of the amount selected for you, the employee.

#### OPTIONS

- Having selected Life Insurance for myself, I wish to have Life Insurance for my child(ren). Select benefit amount.
- I currently have Life Insurance for my child(ren) and am making a change. Select benefit amount.
- 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 for your child(ren)-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 Statement of Health for each covered child. Please go to our website [www.dbm.maryland.gov](http://www.dbm.maryland.gov) to download the Statement of Health form for each covered child.

Fill in the amount of Benefit

\$     ,

### Employee Signature

Please enroll me for the Flexible 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 pay based on the choices I have made. 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 to 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. **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 Section 125 of the Internal Revenue Code and COMAR 17.04.13.04.**

I understand that if I have enrolled in one or both of the Flexible Spending Accounts, that I must file for reimbursement from those accounts by October 15, 2011 in order to avoid losing my contributions, and that my decision to deposit funds in the Spending Accounts is binding through June 30, 2011 and can only be modified if there is a qualifying change in status permitted by Section 125 of the Internal Revenue Code.

I understand that the Flexible 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 2010-JUNE 2011. 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 June 30, 2011. **I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for any type of duplicate coverage.**

**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 CANCELED. I MAY BE REQUIRED TO REPAY ANY CLAIMS AND INSURANCE PREMIUMS WHICH HAVE BEEN PAID INAPPROPRIATELY, I MAY FACE CHARGES FOR DISMISSAL FROM STATE SERVICE, AND I MAY FACE CRIMINAL INVESTIGATION AND PROSECUTION.**

**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 representative before signing this application.**

Is there any other health insurance coverage in which you, your spouse, domestic partner or any of your dependents are enrolled?  Yes  No Effective Date: \_\_\_\_\_

Specify who is covered, name of Insurance Company and Policy Number: \_\_\_\_\_

I certify that I have discussed a Retroactive Adjustment with my Agency Benefits Coordinator.

X \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Employee Signature Date Work Phone Number (Ext.) Your Home/Cell Phone Number

### Agency Signature - Agency Must Sign Here FORMS WILL NOT BE PROCESSED WITHOUT AN AGENCY SIGNATURE

I hereby certify that the person applying for enrollment is employed by the Agency. I certify that I have discussed a Retroactive Adjustment with the employee and have reviewed the form and accompanying documents for accuracy.

X \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Agency Benefits Coordinator Date Work Phone Number (Ext.) Department