STATE OF MARYLAND

DIRECT PAY ENROLLMENT FORM
JULY 2011-JUNE 2012 HEALTH BENEFITS

PERSONAL DATA *PLEASE PRINT CLEARLY*

EMPLOYEE/RETIREE INFORMATION

Name:
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** ○ **Female**

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

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

Name:
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** ○ **Female**

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

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

STATUS

○ 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)

ENROLLMENT/CHANGE ACTION REQUESTED

○ Open Enrollment
○ New Enrollment
○ Cancel All Coverage in All Plans
○ 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: __________
○ Date of Death: __________
(Attach copy of Death Certificate)
○ Dependent no longer eligible. Explain: __________
____
○ Other: ______________________

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

Employee Benefits Division
Direct Pay / Satellite 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

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

ENROLLMENT FOR JULY 2011-JUNE 2012

DEPENDENT INFORMATION *PLEASE PRINT*

Dependent means your eligible: (a) spouse, (b) same sex domestic partner, (c) dependent child(ren) (including biological child, adopted child, stepchild, grandchild, step grandchild, legal ward), (d) domestic partner's dependent child(ren) (including biological child, adopted child, stepchild, grandchild, step grandchild, 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 MUST BE FILLED OUT COMPLETELY (INCLUDING SOCIAL SECURITY NUMBER AND DATE OF BIRTH) TO ENSURE YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECTED.** You may 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	RELATIONSHIP	DOMESTIC PARTNER DEPENDENT (Y/N)	SOCIAL SECURITY NO.	(✓) COVER THIS DEPENDENT FOR:		
								MEDICAL	DRUG	DENTAL
				MM/DD/YYYY						
				MM/DD/YYYY						
				MM/DD/YYYY						
				MM/DD/YYYY						
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Special Notifications:

- Tax-qualified dependent children of either the employee or domestic partner age 26 and over must be disabled prior to reaching age 26 in order to be eligible for continued coverage.
- Some dependents are not eligible for tax-favored coverage and you may owe increased taxes if the State subsidizes dependent coverage for individuals who are not your tax dependents. Refer to the Benefits Guide for details.

ENROLLMENT FOR JULY 2011-JUNE 2012

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

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

COVERAGE LEVEL
- ○ Individual Only
- ○ Individual & One Child; name: ____________________
- ○ Individual & Spouse
- ○ Individual & Domestic Partner
- ○ Individual & Family
- ○ End Stage Renal (ESRD) (Complete Medicare Information below)

MEDICAL PLANS

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*

The plans with an asterick (*) require a Primary Care Physician once enrolled. See plan website for details.

NOTE: Vision and Mental Health/Substance Abuse benefits are available 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, write in name, Medicare number, effective date of Medicare coverage level.

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		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
Spouse		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
Domestic Partner		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
Child		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			
Child		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY			

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

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

COVERAGE LEVEL
- ○ Individual Only
- ○ Individual & One Child; name: ____________________
- ○ Individual & Spouse
- ○ Individual & Domestic Partner
- ○ Individual & Family

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

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
- ○ Individual Only
- ○ Individual & One Child; name: ____________________
- ○ Individual & Spouse
- ○ Individual & Domestic Partner
- ○ Individual & Family

DENTAL PLANS
1. ○ United Concordia DPPO
2. ○ United Concordia DHMO

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

Accidental Death and Dismemberment Benefits - Available to LAW/Contractual/Part-Time Only

OPTIONS
- ○ New enrollment or addition/removal of dependent
- ○ Change of benefit amount - select benefit amount
- ○ No, I do not want to enroll in this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Individual Only coverage
- ○ Family coverage

BENEFIT AMOUNT
- ○ $100,000
- ○ $200,000
- ○ $300,000

Flexible Spending Accounts - Health Care - Available to COBRA and LAW Only

***For Employees Who Had Flexible Spending Accounts During Active Status In July 2011-June 2012.**

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

THIS IS NOT A PRE-TAX BENEFIT WHILE IN DIRECT PAY STATUS AND FUNDS MUST BE USED BY OCTOBER 15, 2012.

Health Care Spending Account
- ○ I want to continue my Health Care Spending Account in July 2011-June 2012. **Note:** COBRA enrollees will be billed for the same total deduction amount as an active employee plus a 2% fee.
- ○ Cancel my Health Care Spending Account. Expenses incurred prior to the cancellation date may be reimbursed up to the limit of your Health Care FSA.

ENROLLMENT FOR JULY 2011-JUNE 2012

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

APPLICANT LIFE INSURANCE

For Contractual/Part-Time Employees Only:

○ Yes, I want to continue my July 2011-June 2012 level of coverage. Select benefit amount.
○ Yes, I want to continue my Life Insurance, but at a different coverage level. Select benefit amount.
○ Yes, I want to enroll as a new enrollee in Life Insurance. Select benefit amount.
○ No, I do not want to enroll in this benefit.
○ Cancel all Life Insurance (applicant and dependent).

***For Employees on LAW:**

○ I want to continue my Life Insurance at the same $ value as an active employee. Select benefit amount.
○ No, I do not want to enroll in this benefit.
○ Cancel all Life Insurance (applicant and dependents).

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 Statement of Health for yourself. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for yourself.

Fill in the amount of Benefit

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Coverage available in increments of $10,000 only

DEPENDENT LIFE INSURANCE

For Contractual/Part-Time Employees Only:

Life Insurance on Spouse/Domestic Partner
○ Yes, I want to continue my spouse's/domestic partner's Life Insurance at the July 2011-June 2012 level.
○ Yes, I want to continue my spouse's/domestic partner's Life Insurance, but at a different amount. Select benefit amount.
○ Yes, I want Life Insurance for my spouse/domestic partner. Select benefit amount.
○ No, I do not want to enroll in this benefit.
○ Cancel Life Insurance on my spouse/domestic partner.

Fill in the amount of Benefit

$ ☐ ☐ ☐ , ■ ■ ■

Spouse/Domestic Partner coverage available (up to 50% of employee's coverage) in increments of $5,000 only, up to $150,000.

Life Insurance on Child(ren)
○ Yes, I want to continue my child(ren)'s Life Insurance at the July 2011-June 2012 level. Select benefit amount.
○ Yes, I want to continue my child(ren)'s Life Insurance, but at a different amount. Select benefit amount.
○ Yes, I want Life Insurance on my child(ren). Select benefit amount.
○ No, I do not want to enroll in this benefit.
○ Cancel Life Insurance on child(ren)

Fill in the amount of Benefit

$ ☐ ☐ ☐ , ■ ■ ■

Child coverage available (up to 50% of employee's coverage) in increments of $5,000 only, up to $150,000.

If you choose an amount greater than $25,000, you must fill out a Life Insurance Statement of Health for your spouse/domestic partner or child. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for each covered spouse/domestic partner or child.

For Employees on LAW (Effective 7/1/2011-6/30/2012)

Continue Life Insurance on Spouse/Domestic Partner
○ I want to continue Life Insurance on my spouse/domestic partner at the same benefit amount as in active status. (Select benefit amount above.)
○ Cancel Life Insurance on my spouse/domestic partner.

Continue Life Insurance for Child(ren)
○ I want to continue Life Insurance on my child(ren) at the same benefit amount as in active status. (Select benefit amount above.)
○ Cancel Life Insurance on my child(ren).

ENROLLMENT FOR JULY 2011-JUNE 2012

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
○ 6. Spouse of a State employee who has elected Medicare as the only coverage and the spouse 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 who is no longer eligible by reason of age, marriage, term of domestic partnership or death of employee	36 months or until eligible for group coverage through another source including Medicare
○ 8. Widowed spouse of a State employee/retiree	36 months or until eligible for group coverage through another source including Medicare
○ 9. Dissolution of domestic partnership with a current 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.***

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 individual 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 individual 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
Employee s Name

of Absence-On the Job Injury effective ______________
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

______________________________ ______ / ______ / ______
Signature of Agency Benefits Coordinator or Appointing Authority Date

____
Phone Number

FISCAL OFFICER - PLEASE PRINT THE FOLLOWING:

Appropriation Code: ☐☐☐ Agency ☐☐☐☐☐ PCA ☐☐☐ TC ☐☐☐☐ R Stars Sub Object

______________________________ ______________________________
Fiscal Officer Name & Phone Number Fiscal Officer Signature

ENROLLMENT FOR JULY 2011-JUNE 2012

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 to 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 except during an Open Enrollment period or as the result of a qualifying change in status permitted by Section 125 of the Internal Revenue Code and 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 in this enrollment form are only in effect for July 2011-June 2012. 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 June 30, 2012. **I certify that neither I nor my 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 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/domestic partner or any of your dependents are enrolled?
○ Yes ○ No

Specify who is covered, name of Insurance Company and Policy Number: ________________________________ ____________
Effective Date

X ____ ____________________
Your Signature Date

X ____ ____________________
AGENCY SIGNATURE - Agency Must Sign Here Date

Agency Code: ________________

Check Dist. Code: ________________

☐☐☐ - ☐☐☐ - ☐☐☐☐
Work Phone Number (Ext.)

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

NOTE:

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND APPROPRIATE DOCUMENTATION ATTACHED TO BE PROCESSED WITHOUT DELAY.