

STATE OF MARYLAND

DIRECT PAY ENROLLMENT FORM

JULY 2010-JUNE 2011 HEALTH BENEFITS

PERSONAL DATA PLEASE PRINT CLEARLY

EMPLOYEE/RETIREE INFORMATION

Name:
Address:
 City _____ State _____ Zip Code _____
Home Phone: () _____ - _____
Work Phone: () _____ - _____
Cell Phone: () _____ - _____
Social Security Number: _____ / _____ / _____
Date of Birth: ____/____/_____

Sex: Male **LEGAL MARITAL STATUS:**
 Female 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: () _____ - _____
Social Security Number: _____ / _____ / _____
Date of Birth: ____/____/_____

Sex: Male **LEGAL MARITAL STATUS:**
 Female 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: _____

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

OPTIONS

- New Enrollment or
 Change in Enrollment
 Addition or removal of
 dependent
 Continue coverage
 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)

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.

Name _____ Medicare Number _____ Date of Coverage ____/____/_____

Name _____ Medicare Number _____ Date of Coverage ____/____/_____

ENROLLMENT FOR JULY 2010-JUNE 2011

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

OPTIONS

- New enrollment
- Addition or removal of dependent
- Continue coverage
- 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
- Continue coverage
- 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

Check only one dental plan:

- 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

(NOT AVAILABLE TO COBRA ENROLLEES)

OPTIONS

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

COVERAGE LEVEL

- Individual 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 2010-June 2011.**
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, 2011.

Health Care Spending Account

- I want to continue my Health Care Spending Account in July 2010-June 2011. **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 2010-JUNE 2011

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 2010-June 2011 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

\$,

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 2010-June 2011 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 2010-June 2011 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 7/1/2010-6/30/2011)**

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 2010-JUNE 2011

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 2010-June 2011. 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, 2011. **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 the listed dependents are eligible for coverage under the benefit plan rules. 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 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 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 _____

Personal Email: _____ Work Email: _____

X _____ AGENCY SIGNATURE - Agency Must Sign Here _____ Date _____

Agency Code: _____ - -
Work Phone Number (Ext.)

Check Dist. Code: _____

NOTE: This form must be completed in its entirety and appropriate documentation attached to be processed without delay.

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

**Employee Benefits Division
Direct Pay 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**

Website: www.dbm.maryland.gov (Click Health Benefits)

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