STATE OF MARYLAND

ACTIVE EMPLOYEES
HEALTH BENEFITS ENROLLMENT AND CHANGE FORM FOR JANUARY 2024-DECEMBER 2024

PERSONAL DATA *PLEASE PRINT CLEARLY*

Name: _____
LAST FIRST MI

Address: _____ **Apt/Condo:** _____

City: _____ **State:** _____ **Zip Code:** _____

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

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

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

Sex:
- ○ Male
- ○ Female

Legal Marital Status:
- ○ Single
- ○ Married
- ○ Divorced
- ○ Limited Divorce/Legally Separated
- ○ Widowed

Personal E-mail: _____

Work E-mail: _____

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

Agency Code: _____ **Check Dist. Code:** _____ ***(if applicable)***

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

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

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

- ○ New Employee Entry on Duty Date: _____
- ○ New Employee Entry on Duty Date: _____ *(Correction within 60 days)*
- ○ Job Change Date: _____
- ○ Job Change Date: _____ *(Correction within 60 days)*
- ○ Return from leave of absence/LAW Date: _____
- ○ Return from leave of absence/LAW Date: _____ *(Correction within 60 days)*
- ○ Open Enrollment - Effective January 1st
- ○ Open Enrollment - Effective January 1st *(Correction)*
- ○ Other Qualifying Event: _____
- ○ Other Qualifying Event: _____ *(Correction within 60 days)*

Change in Family Status (See Benefits Guide for documentation requirements)
Note: 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: _____
- ○ **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: _____
- ○ Other Change: _____

COMPLETED AND SIGNED ENROLLMENT FORMS MUST BE GIVEN TO YOUR AGENCY BENEFITS COORDINATOR

If you are enrolling dependents,
all required dependent documentation must be attached.
Health benefits information and forms are available on our website:
www.dbm.maryland.gov/benefits

ENROLLMENT FOR JANUARY 2024-DECEMBER 2024

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 provide your dependent information below. **PLEASE PRINT. THIS FORM MUST BE FILLED OUT COMPLETELY (INCLUDING SOCIAL SECURITY NUMBER AND DATE OF BIRTH) TO ENSURE YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECT.** 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)*	*SOCIAL SECURITY NO.*	*(✓) COVER THIS DEPENDENT FOR:*		
								MEDICAL	*DRUG*	*DENTAL*
								☐	☐	☐
								☐	☐	☐
								☐	☐	☐
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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 employee may owe increased taxes if the State subsidizes dependent coverage. Refer to the Benefits Guide for details.

ENROLLMENT FOR JANUARY 2024-DECEMBER 2024

Medical Benefits

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

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:
- ○ Employee Only
- ○ Employee & One Child
- ○ Employee & Spouse
- ○ Employee & Family
- ○ Employee & Domestic Partner
- ○ End Stage Renal Disease (ESRD) (Complete Medicare Information below)

CHOOSE ONE MEDICAL PLAN:
- ○ CareFirst BC/BS EPO
- ○ CareFirst BC/BS PPO
- ○ Kaiser IHM*
- ○ UnitedHealthcare EPO
- ○ UnitedHealthcare PPO

Bargaining Unit I members only (SLEOLA):
- ○ CareFirst BC/BS EPO Mod-I
- ○ CareFirst BC/BS POS Mod-I
- ○ CareFirst BC/BS PPO Mod-I

NOTE: Vision benefits <u>are included</u> if enrolled in a medical plan.
****Employees and/or dependents with Medicare due to End Stage Renal Disease (ESRD) are not eligible to enroll in the Kaiser medical plan.***
If you or a dependent have Medicare, write in name, Medicare number, and effective date of Medicare coverage.

NAMES OF INDIVIDUALS 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
Employee					☐	☐	☐
Spouse					☐	☐	☐
Domestic Partner					☐	☐	☐
Child					☐	☐	☐
Child					☐	☐	☐

Prescription Drug Coverage

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:
- ○ Employee Only
- ○ Employee & One Child
- ○ Employee & Spouse
- ○ Employee & Family
- ○ Employee & Domestic Partner

Dental Coverage

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:
- ○ Employee Only
- ○ Employee & One Child
- ○ Employee & Spouse
- ○ Employee & Family
- ○ Employee & Domestic Partner

CHOOSE ONE DENTAL PLAN:
- ○ United Concordia DPPO
- ○ Delta Dental 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

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:
- ○ Employee Only coverage
- ○ Family coverage

CHOOSE ONE BENEFIT AMOUNT:
- ○ $100,000
- ○ $200,000
- ○ $300,000

Flexible Spending Accounts - Domestic partners and the dependent children of domestic partners are not eligible for FSA reimbursement

<u>YOU MUST COMPLETE THIS SECTION IF YOU WANT TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT FROM JANUARY 2024-DECEMBER 2024.</u>

HEALTHCARE

CHOOSE ONE OPTION:
- ○ Enroll in Healthcare Spending Account
- ○ Change in Healthcare Spending Account
- ○ No, I do not want to enroll in this benefit
- ○ Cancel Healthcare Spending Account

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*Write in **Annual Election Amount***

DAY CARE

CHOOSE ONE OPTION:
- ○ Enroll in Dependent Day Care Spending Account
- ○ Change in Dependent Day Care Spending Account
- ○ No, I do not want to enroll in this benefit
- ○ Cancel Dependent Day Care Spending Account

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*Write in **Annual Election Amount***

If you will be retiring before January 1, 2025, only expenses incurred on or before the last day of employment can be considered for reimbursement.

See Benefits Guide for Minimum/Maximum deduction amounts. The per pay amount will be determined based on the number of pay periods left in the plan year when you are eligible for enrollment.

ENROLLMENT FOR JANUARY 2024-DECEMBER 2024

Life Insurance Plan

EMPLOYEE

OPTIONS-Choose only one

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

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 Evidence of Insurability form. The life insurance vendor will contact you about completing this form. Amount over $50,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

$ ☐☐0,000

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**.

OPTIONS-Choose only one

- ○ Having selected Life Insurance for myself, I wish to have Life Insurance on my spouse/domestic partner.
- ○ I currently have Life Insurance for my spouse/ domestic partner and am making a change.
- ○ 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 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 for your spouse/domestic partner. The life insurance vendor will contact you about completing this form. Amount over $25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

$ ☐☐☐,000

CHILDREN

SECTION 3: CHILD(REN) 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**.

OPTIONS-Choose only one

- ○ Having selected Life Insurance for myself, I wish to have Life Insurance for my child(ren).
- ○ I currently have Life Insurance for my child(ren) and am making a change.
- ○ 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 up to 1/2 of the amount chosen for yourself, up to $150,000:

STOP-Amounts over $25,000 will not be effective until we receive approval from the life insurance carrier regarding the employee's coverage above $50,000, if applicable.

Fill in the amount of Benefit

$ ☐☐☐,000

Employee 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 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 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. 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 change in status permitted by COMAR 17.04.13.04 and IRS Section 125.**

I understand that if I have enrolled in the Healthcare Flexible Spending Account, that I may seek reimbursement for services incurred through March 15, 2025 or the last day of employment, whichever is earlier. I also understand that if I am enrolled in one or both of the Flexible Spending Accounts I must file for reimbursement by April 15, 2025 in order to avoid losing my contributions and that my decision to deposit funds in the Spending Accounts is binding through the end of the current plan year 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 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 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 neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership 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 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 I may face criminal investigation and prosecution.

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 employee/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 my Agency Benefit Coordinator or 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.

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

X _____ _____/_____/_____

Employee Signature — Date

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 department before signing this application. Plan phone numbers are listed on the inside front cover of the Benefits Guide.

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

I hereby certify that I have reviewed the form and all accompanying documents for accuracy.

X _____ _____/_____/_____ (_____) _____ _____

Agency Benefits Coordinator Signature — Date — Work Phone Number (Ext.) — Department

_____ (_____) _____

Agency Benefits Coordinator Email Address — Fax Number