# **STATE OF MARYLAND** DIRECT PAY ENROLLMENT FORM **JANUARY 2015-DECEMBER 2015 HEALTH BENEFITS**

# PERSONAL DATA PLEASE PRINT CLEARLY

EMPLOYEE/FORMER EMPLOYEE/RETIREE INFORMATIO	N FORMER DEPENDENT INFORMATION (if different from employee's information)
Name:	_ Name:
Address: Apt/Condo:	
City:State:Zip Code:	_ City:State:Zip Code:
Home Phone: ()	Home Phone: ()
Work Phone: ()	Work Phone: ()
Cell Phone: ()	Cell Phone: ()
Personal E-mail:	Personal E-mail:
Work E-mail:	
Social Security Number: / / /	Social Security Number: / / /
Date of Birth:/_/	Date of Birth://
Sex: Male LEGAL MARITAL STATUS: Female Single Widowed Married Divorced Limited Divorce/Legal Separation	Sex: Male LEGAL MARITAL STATUS: Female Single Widowed Married Divorced Limited Divorce/Legal Separation
STATUS & ENROLLMENT/	CHANGE ACTION REQUESTED
COBRA Date of Qualifying Event:	Open Enrollment - Effective January 1st
Are you on Medicare? Yes No	New Enrollment
Part-Time Employee (Less than 50%)	Cancel all Coverage in all Plans/Reason:
LAW-MILITARY (Long Term Leave of Absence – Military) Effective Date of LAW-MILITARY:	<b>Change in Family Status</b> (See Benefits Guide for documentation requirements) Note: Request must be made within 60 days of the date of the qualifying event
End Date of LAW-MILITARY:	Add dependent because of:
LAW – PERSONAL	Marriage Date:
(Long Term Leave of Absence Without Pay)	Birth/Adoption/Appointed Permanent Legal Guardian
Effective Date of LAW-PERSONAL:	Date:
End Date of LAW-PERSONAL:	Other/Reason:
(May not exceed 2 years)	Remove dependent because of:
LAW-OJI (Long Term Leave of Absence – On the Job Injury)	Divorce/Limited Divorce/Legal Separation Date:
Effective Date of LAW-OJI:	Death Date (Attach copy of Death Certificate)
End Date of LAW-OJI:	Dependent no longer eligible Date:
(May not exceed 2 years)	Reason: Other:

# **COMPLETED AND SIGNED ENROLLMENT FORMS MAY BE MAILED OR HAND-DELIVERED TO:**

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

EBD Use Only:
Reviewed
Processed
Audited

Hours of Operations: 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: www.dbm.maryland.gov/benefits

# **ENROLLMENT FOR JANUARY 2015-DECEMBER 2015**

# **DEPENDENT INFORMATION** PLEASE PRINT

Dependent means your eligible: (a) spouse, or (b) dependent child(ren) (including biological child, adopted child, stepchild, 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 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 D	DATE OF BIRTH MM/DD/YYYY	RELATIONSHIP	SOCIAL SECURITY NO.	$(\checkmark)$ Cover this dependent for:		
C C			SEA	MM/DD/YYYY	KLLATIONSIIII	BOCHE BECCHITTO.	MEDICAL	DRUG	DENTAL

**Special Notifications:** 

• Tax-qualified dependent children age 26 and over must have become disabled prior to reaching age 26 in order to be eligible for continued coverage.

• Grandchildren and Legal Wards age 25 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 JANUARY 2015-DECEMBER 2015

# **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:		Mark the event, if different, that applies to your dependent:				
QUALIFYING EVENT	MAXIMUM PERIOD OF TIME ELIGIBLE FOR CONTINUATION*	QUALIFYING EVENT	MAXIMUM PERIOD OF TIME ELIGIBLE FOR CONTINUATION*			
<ol> <li>Terminated employee (other than for gross misconduct)</li> </ol>	18 months or until eligible for group coverage through another source including Medicare	<ol> <li>Spouse or child of a State employee/retiree who has elected Medicare as the only coverage and the spouse or child is not eligible for Medicare</li> </ol>	36 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	<ol> <li>Previously dependent child of an employee/ retiree who is no longer eligible by reason of age or death of employee</li> </ol>	36 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	8. Death of a State employee/retiree	36 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	* The period of continuation of coverage is the eligible for coverage elsewhere, whichever				
<ol> <li>Divorce or legally separated spouse of a current State employee/retiree</li> </ol>	Indefinitely or at the time of remarriage or until eligible for group coverage through another					

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

#### 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:

Individual Only Individual & One Child Individual & Spouse Individual & Family End Stage Renal (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) on LAW:

CareFirst BC/BS EPO Mod-I CareFirst BC/BS POS Mod-I CareFirst BC/BS PPO Mod-I

\*Members and/or dependents eligible for Medicare due to age, disability, or End Stage Renal Disease (ESRD) are not eligible to enroll in the Kaiser medical plan. NOTE: Vision and Mental Health/Substance Abuse benefits <u>are included</u> if enrolled in a medical plan. Medical plans <u>do not include</u> Prescription Drug or Dental coverage. Separate selections are required. If you or a dependent have Medicare, please write in name, Medicare number, and effective date of Medicare coverage.

NAMES OF INDIVIDUALS WITH MEDICARE	MEDICARE NUMBER (with suffix)	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	CARE DUE Disabled	TO (√): ESRD
Employee						
Spouse						
Child						
Child						

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

#### 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:

Individual Only Individual & One Child Individual & Spouse Individual & Family

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

#### 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: Individual Only Individual & One Child Individual & Spouse Individual & Family

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 - Available to LAW/Part-Time

Family coverage

## 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: Individual Only coverage CHOOSE ONE BENEFIT AMOUNT: \$100,000 \$200,000 \$300,000

# Flexible Spending Account - Healthcare - Available to COBRA and LAW

\*For Employees Who Had Flexible Spending Accounts During Active Status during the January 2015-December 2015 plan year.

#### THIS IS NOT A PRE-TAX BENEFIT WHILE IN DIRECT PAY STATUS AND SERVICES MUST BE INCURRED BY MARCH 15, 2016.

#### **Healthcare Spending Account**

I want to continue my Healthcare Spending Account for January 2015-December 2015. **Note:** COBRA enrollees will be billed for the same total deduction amount as an active employee plus a 2% fee on a post-tax basis.

Cancel my Healthcare Spending Account. Expenses incurred prior to the cancellation date may be reimbursed up to the limit of your Healthcare FSA.

Li	fe	Insurance -	- Available to	o LAW/Part-Time

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LAW - Long Term Leave Without Pay Due to a Job-Related Injury or Military Leave.         If the long term LAW is the result of a job-related accident or injury (LAW-OI) or Military Leave. the State will ray the State torm of the endoty of the storm of the inter coord of a low related accident or injury (LAW-OI) or Military Leave. the State will ray the State storm of the endoty will be billed directly by the Department of Budget & Management for the anount due.         AGENCY BENEFITS COORDINATOR - PLEASE PRINT THE FOLLOWING:	Yes, I want Life Insurance for my sp Yes, I want to continue my spouse's Yes, I want to continue my spouse's No, I do not want to enroll in this be	Life Insurance Life Insurance, but at a different amount. enefit.		Yes, I wai Yes, I wai Yes, I wai No, I do r	ant Life ant to co ant to co not wan	fe Insurance on my child(ren). continue my child(ren)'s Life Insurance continue my child(ren)'s Life Insurance, but at a different amount. rant to enroll in this benefit.	
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Active employee parties. A copy of the first report of injury form mask be submitted with this enrollment form. If the loss the omy other reason, the employee missing provide present of the periment of the annound due. AGENCY BENEFITS COORDINATOR - PLEASE PRINT THE FOLLOWING: A	LAW - Long Term	Leave Without Pay L	ue to a Job-	Related	Inj	jury or Military Leave	
Englowes Nume       Date         B. Anticipated date of return to work:	Active employee portion. A copy must pay 100 percent of the premi	of the first report of injury form must b ium. In either case the employee will be	e submitted with this en e billed directly by the l	nrollment forr Department of	m. If tl	f the long term LAW is due to any other reason, the employed	
B. Anticipated date of return to work:	A	nlovee s Name	is on Approved I	Leave of Ab	sence	· · · · · · · · · · · · · · · · · · ·	
Due     C. Is this an initial LAW-OJI? Yes No OR Is this an extension of a previous Long Term LAW-OJI? Yes No     FISCAL OFFICER - PLEASE PRINT THE FOLLOWING:     Agency BIO THE FOLLOWING:     Fired Officer Name & Pisses Number     Fired Officer Signature & Pisses Number     Fired Officer Name & Pisses Number     Fired Officer Name & Pisses Number     Fired Officer Name & Pisses Number     Fired Officer Signature & Pisses Number     Fired Officer Name & Pisses Number     Fired Officer Signature     Agency Use Name A Pisses Number     Fired Officer Signature Pisses     Management of Studget & Management regulations. The pressonal information provided on this enrollment form is warranted to be complete, accurate, and in accordance     with DeStructure of Diddeer & Management regulations. The Mandatory Insurer Reporting Law 42 U S C. 1995(VC) // Pisses Pisses Number     Fired Office Internet of Diddeer & Management regulations. The Mandatory Insurer Reporting Law 42 U S C. 1995(VC) // Pisses Number     Fired Office Internet regulations. The Mandatory Insurer Reporting Law 42 U S C. 1995(VC) // Pisses Pisses Number     Fired Office Internet regulations Information provided on this enrollment form is warranted to be complete, accurate, and in accordance     with DeStructure of Taget Pisses Number     Fired Officer Signature Reported Information Integence Norentophytochytochytochytochytochytochytochytoc	-					Date	
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Agency       PCA       TC       R starts sub-Object         Fixed Officer Name & Plone Number       Fixed Officer Signature         Applicant and Agency Signatures       Fixed Officer Signature         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.       Fixed Officer Signature         Please enroll me for the benefits indicated on this torm. I understand the benefits and imitations provided by the various plans. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, 1 authorize the release of all medical records and related information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget & Management regulations. The Mandatory Insurer Reporting Law 42 U.S.C. 1395y(b)(7) requires group health plans to report SNs 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 period or as the result of a qualifying change in family status permitted by COMAR 17.04.13.04 and 18S Section 125.         Tunderstand that the Benefits Invested by the State is subject to modifications and changes and that the benefits indicate on status value of a status in status permitted by COMAR 17.04.13.04 and 18S Section 125.         Tunderstand that the Benefits induced for coverage are eligible for coverage in the plan status are not entilised is considered fraud. In all cases I am responsible for the accuracy of my benefits, towich I am orm					us L	Long Term LAW-OFF TES TRO	
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 neetaining 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 & 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. Lunderstand that I cannot cancel or change my enrollment elections except during an Open Enrollment period or as the result of a qualifying change in family status permitted by COMAR 17.04.13.04 and IRS Section 125.         I understand that the Benefits Proved of the state is subject to modifications and changes and that the benefits I have chosen on this errollment form are only in effect for January 2015-December 2015. The State of Maryland reserves the right to modify any benefits provided and gives no assurances, expressed or implied, that any coverage are eligible for coverage. I understand that the modify any benefits to which I am or my dependents are covered under another State of Maryland employee's or retire's membership for any coverage for which I or they are enrolled on this form.         I contribution is understand that envirous plans. To the extent deemed metaide information. Lunderstand that involute beyond December 31, 2015. I certify th	Appropriation Code:	Agency PC	]	TC		R Stars Sub Object	
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 protided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget & Management regulations. The Mandatory Insurer Reporting Law 2 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 1 cannot cancel or change my enrollment elections except during an Open Enrollment period or as the result of a qualifying change in family status permitted by COMAR 17.04.13.04 and IRS Section 125.         I understand that the Benefits Thave change on obtifications and changes and that the benefits I have chosen on this errollment form are only in effect for January 2015-December 2015. The State of Maryland reserves the right to modify any benefits provided and gives no assurances, expressed or implied, that any coverage are eligible for coverage. I understand that the moleritis to which I am or my coverad dependents are covered under another State of Maryland employee's or retire's membership for any coverage for which I or they are enrolled on this form.         I understand that if willfullin withere isosolitily of myself or my dependents are	Fisca	I Officer Name & Phone Number				Fiscal Officer Signature	
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, 1 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 & 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 elections except during an Open Enrollment period or as the result of a qualifying change in family status permitted by COMAR 17.04.13.04 and IRS Section 125. Indicated on the Benefits To avecage obtained hereunder will continue beyond December 31, 2015. Tertify 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 my coverage level and ny dependents listed for coverage are eligible for coverage. I understand that encollment form, or fail to take the necessary action to remove ineligible dependents, and in all cases I am responsible for the accuracy of my benefits, quereels and premiums. I further understand that I willfully of myself or my dependents are period or any dependents are out entitled in sonsider of my dependents are out entitled in Somity of myself or my dependents are period.	Applicant and Age	ency Signatures					
X YOUR SIGNATURE Date Date	<i>member service representat</i> Please enroll me for the b necessary by the Plan Admi pertaining to me or my depe with Department of Budget report SSNs in order for Me Guide and on our website for <b>Open Enrollment period o</b> I understand that the Bend enrollment form are only in no assurances, expressed or <b>covered dependents are co</b> <b>enrolled on this form.</b> I certify that I and any dependents are not entitled if further understand that if I w action to remove ineligible of any claims and insurance pri- Is there any other health No Yes	ive before signing this application enefits indicated on this form. I un nistrator for the proper administrati- endents. The personal information p & Management regulations. The M valicare to coordinate payments with or more detailed information. I und r as the result of a qualifying cha- effect for January 2015-December implied, that any coverage obtaine vered under another State of Ma pendents listed for coverage are eli s considered fraud. In all cases I a villfully misrepresent the eligibility dependents, or in any way obtain b emiums, and I may face criminal in h insurance in which you, you	derstand the benefits ion of my coverages, provided on this enro fandatory Insurer Re n other insurance ben <b>lerstand that I cann</b> ange in family status is subject to modifica 2015. The State of M d hereunder will con <b>ryland employee's</b> gible for coverage. I <b>um responsible for t</b> of myself or my dep enefits to which I am nvestigation and pros <b>ur spouse or any o</b>	and limitati I authorize Ilment form porting Law efits. Please ot cancel on s permitted ttions and ch Maryland rest tinue beyond or retiree's understand he accuracy bendents on n not entitled secution. f your dep	ions p the re- is way 42 U e refer r chan by C hanges serves d Dec mem that e y of m my b d, my bende	provided by the various plans. To the extent deemed release of all medical records and related information warranted to be complete, accurate, and in accordance U.S.C. 1395y(b)(7) requires group health plans to er to our Notice of Privacy Practices in the Benefit ange my enrollment elections except during an COMAR 17.04.13.04 and IRS Section 125. ges and that the benefits I have chosen on this es the right to modify any benefits provided and gives ecember 31, 2015. I certify that neither I nor my mbership for any coverage for which I or they are are enrollment in benefits to which I am or my my benefits, coverage levels and premiums. I benefits application, or fail to take the necessary y benefits will be canceled, I will be required to repay dents are enrolled?	
X YOUR SIGNATURE Date Date							
X	X					Effective Date	
Work Phone Number (Ext.)     Fax Number       Check Dist. Code:	x	YOUR SIGNATURE				Date	
Work Phone Number (Ext.)     Fax Number       Check Dist. Code:	A gapay Cada:	AGENCY SIGNATURE - Agency M	lust Sign			Date	
Check Dist. Code:			Work Phone Number (Ext.	)		Fax Number	
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