STATE OF MARYLAND

RETIREE HEALTH BENEFITS ENROLLMENT FORM JULY 2010-JUNE 2011

PERSONAL DATA *PLEASE PRINT CLEARLY*

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

CONTACT INFORMATION:

Home Phone: (__ __ __) __ __ __- __ __ __ __

Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Work Phone: (__ __ __) __ __ __ - __ __ __ __

Home E-mail Address: _____

Work E-mail Address: _____

DATE OF BIRTH: (mm/dd/yyyy): __ __/ __ __/ __ __ __ __

SOCIAL SECURITY NUMBER: __ __ __ /__ __ / __ __ __ __

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

MY STATUS:

○ Maryland State Retirement System Retiree; or
  ○ Surviving Beneficiary; relationship:_____

○ Optional Retirement Plan (ORP) Retiree (i.e., TIAA-CREF); or
  ○ Surviving Beneficiary; relationship:_____

○ Satellite Retiree; (Agency Name:_____); or
  ○ Surviving Beneficiary; relationship:_____

ADDRESS CHANGE OR CORRECTION:

☐ CHANGE ☐ CORRECTION

_____
Street

_____
Apt #

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

ENROLLMENT/CHANGE REQUESTED

○ **New Retiree;** Date: _____
  Last Day of State employment: _____

○ **New Beneficiary** of Deceased Retiree
  Name of Deceased: _____
  Date Deceased: _____

○ **Medicare Eligibility**
  (Complete Medicare Information Section, page 3)

○ **Open Enrollment**

○ **Cancel all Coverage** in all Plans/Explain: _____
_____

○ **Other**/Explain: _____

Change in Family Status

○ **Add Dependent** because of:
  ○ Marriage; Date: _____
  ○ Domestic Partnership
  ○ Birth/Adoption/Appointed Permanent Legal Guardian;
    Date: _____
  ○ Other; Explain: _____

○ **Remove Dependent** because of:
  ○ Divorce/Legal Separation/Dissolution of Domestic Partnership;
    Date: _____
  ○ Death; Date: _____ ***(Attach copy of Death Certificate)***
  ○ Dependent no longer eligible; Date: _____
    Explain: _____

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

Employee Benefits Division
301 W. Preston Street, Room 510
Baltimore, Maryland 21201
FAX: 410-333-7104

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 2010-JUNE 2011

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 use this section to add (A), delete (D) or make a change/correction (C) to your existing dependent information. If you are a new Retiree, you must add all information for all covered dependents to your Retiree Dependent Information, including those who were covered dependents under your Active employee enrollment. **PLEASE PRINT CLEARLY ALL INFORMATION, INCLUDING SOCIAL SECURITY NUMBER, DATE OF BIRTH, AND IF THE DEPENDENT IS ELIGIBLE FOR MEDICARE DUE TO AGE (AGE 65) OR DISABILITY (ANY AGE) TO ENSURE THAT YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECTED AND CLAIMS ARE PAID PROPERLY.**

A D C	*LAST NAME*	*FIRST NAME, MI*	*SEX*	*DATE OF BIRTH*	*RELATIONSHIP*	*DOMESTIC PARTNER DEPENDENT (Y/N)*	*ELIGIBLE FOR MEDICARE (Y/N)*	*SOCIAL SECURITY NO.*	*(✓) COVER THIS DEPENDENT FOR:*		
									MEDICAL	*DRUG*	*DENTAL*

Special Notifications:

- Tax-qualified dependent children age 25 and over, of either the Retiree or Domestic Partner, must be disabled prior to reaching age 25 in order to be eligible for continued coverage.
- Some dependents are not eligible for tax-favored coverage and you may owe increased income 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 2010-JUNE 2011

Medical Benefits - A Beneficiary is considered a "Retiree"

Choose One Option:

- ○ New Enrollment or Change in Medical Plan
- ○ Add or Remove a Dependent
- ○ Change due to Medicare Eligibility
- ○ I do not want Medical Coverage
- ○ Cancel current Medical Coverage

Choose One Coverage Level:

Choose from #1 to #5 if no one covered is eligible for Medicare Parts A & B

1. ○ Retiree Only, No Medicare
2. ○ Retiree & One Child, No Medicare; Name:_____
3. ○ Retiree & Spouse, No Medicare
4. ○ Retiree & Domestic Partner, No Medicare
5. ○ Retiree & Two or More, No Medicare

Choose from #6 to #12 if anyone covered is eligible for Medicare (the Retiree must be one of the individuals covered):

6. ○ Retiree Only (with Medicare Parts A & B)
7. ○ Two People (only one with Medicare Parts A & B)
8. ○ Two People (both with Medicare Parts A & B)
9. ○ Three People (only one with Medicare Parts A & B)
10. ○ Three People (only two with Medicare Parts A & B)
11. ○ Three or More People (all with Medicare Parts A & B)
12. ○ Four or More People (at least one, but not all with Medicare Parts A & B)

Choose One Medical Plan:

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*

For the plans with an asterisk (*): Once enrolled, you must contact the plan to select a Primary Care Physician. Call plan or see plan website for details.

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.

Medicare Information - A Beneficiary is considered a "Retiree"

Medicare information must be provided for anyone covered under your Retiree group policy who is eligible for Medicare due to age (age 65) or disability (any age). Medicare-eligible individuals who do not carry both Part A (Hospital) and Part B (Medical) will be responsible for paying the amount that Medicare would have paid (approximately 80% of all eligible services). For example, a Medicare-eligible Retiree who incurs a $100.00 Part B claim and does not carry Part B, will be responsible for paying the amount that Medicare Part B would have covered (approximately $80.00). Medicare rules for End Stage Renal Disease (ESRD) differ; call the Employee Benefits Division for more information. ***NOTE: Medicare Part D (Prescription drug) 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*
Retiree							
Spouse							
Domestic Partner							
Child							
Child							

Prescription Drug - A Beneficiary is considered a "Retiree"

Choose One Option:

- ○ New Enrollment
- ○ Add or Remove a Dependent
- ○ Change due to Medicare Part D
- ○ I do not want Prescription Drug Coverage
- ○ Cancel current Prescription Drug Coverage

Choose One Coverage Level:

- ○ Retiree Only
- ○ Retiree & One Child; Child's Name: _____
- ○ Retiree & Spouse
- ○ Retiree & Domestic Partner
- ○ Retiree & Two or More People

Dental - A Beneficiary is considered a "Retiree"

Choose One Option:

- ○ New Enrollment or Change in Dental Plan
- ○ Add or Remove a Dependent
- ○ I do not want Dental Coverage
- ○ Cancel current Dental Coverage

Choose One Coverage Level:

- ○ Retiree Only
- ○ Retiree & One Child; Child's Name: _____
- ○ Retiree & Spouse
- ○ Retiree & Domestic Partner
- ○ Retiree & Two or More People

Choose One Plan:

- ○ United Concordia DPPO
- ○ United Concordia DHMO

For DHMO Plan: Once enrolled, you must contact the plan to select a primary Dentist office. Call plan or see plan website for details.

ENROLLMENT FOR JULY 2010-JUNE 2011

Life Insurance

Retirees cannot have a break in Life Insurance coverage between employment and retirement, increase the amount of coverage or add new dependents upon or after retirement. Retirees (new or existing) may only continue, decrease or cancel Life Insurance for themselves and their eligible dependents who are enrolled in Life Insurance at the time of retirement. **If you choose to decrease or cancel coverage, you cannot re-enroll or increase coverage in the future.** Surviving Beneficiaries who were enrolled in Dependent Life Insurance under the deceased Retiree may only continue Life Insurance through a conversion policy purchased directly from the plan.

RETIREE

Choose One Option:

○ Continue Life Insurance *(No break between Employee and Retiree coverage)*
○ Decrease Life Insurance *(You cannot increase in the future)*
○ Cancel Life Insurance *(You cannot re-enroll in the future)*

Choose a coverage amount in increments of $10,000 for yourself (must be equal to or less than current coverage):

Fill in the amount of Benefit

$ ☐ ☐ 0 , ■ ■ ■

SPOUSE/ DOMESTIC PARTNER

Choose One Option:

○ Continue Spouse/Domestic Partner Life Insurance *(No break between Employee and Retiree coverage)*
○ Decrease Spouse/Domestic Partner Life Insurance *(You cannot increase in the future)*
○ Cancel Spouse/Domestic Partner Life Insurance *(You cannot re-enroll in the future)*

Choose a coverage amount in increments of $5,000 for your spouse or domestic partner up to 1/2 of the amount chosen for yourself (must be equal to or less than current coverage):

Fill in the amount of Benefit

$ ☐ ☐ ☐ , ■ ■ ■

CHILDREN

Choose One Option:

○ Continue Child Life Insurance benefits *(No break between Employee and Retiree coverage)*
○ Decrease Child Life Insurance benefits *(You cannot increase in the future)*
○ Cancel Child Life Insurance benefits *(You cannot re-enroll in the future)*

Choose a coverage amount in increments of $5,000 for your and/or your domestic partner's children up to 1/2 of the amount chosen for yourself (must be equal to or less than current coverage):

Fill in the amount of Benefit

$ ☐ ☐ ☐ , ■ ■ ■

NOTE: See Benefit Guide for information about automatic reductions in Life Insurance coverage beginning at age 65.

Retiree 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 retirement allowance based on the choices I have made. I agree to make any premium payments necessary if my retirement allowance will not support the necessary deductions. I understand that to the extent the State subsidizes or pays part of the cost of my coverages, there may be tax consequences to me if I cover dependents who are not my tax dependents. 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 to the benefit plans. The personal information provided on this enrollment form is complete, accurate, and in accordance with the Department of Budget and Management regulations. I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a qualifying event in accordance with COMAR 17.04.13.04.

I understand that the Benefit Program offered by the State is subject to modifications and changes and that the benefits I have chosen in this enrollment 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 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 cancelled and I will be required to repay any claims and/or insurance premiums.

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.

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. Plan phone numbers are listed on the inside front cover of the Benefits Guide.

Other than Medicare and your State of Maryland benefits, do you, your spouse/domestic partner, or any of your dependents have other health insurance?
○ Yes ○ No Specify who is covered, name of Insurance Company: _____

Policy Number:_____ and Effective Date: _____

X _____ ____/_____/_____
Retiree/Beneficiary Signature Date