STATE OF MARYLAND

RETIREE HEALTH BENEFITS ENROLLMENT AND CHANGE FORM JANUARY 2014-DECEMBER 2014

PERSONAL DATA PLEASE PRINT CLEAR	LY				
NAME: LAST FIR	ST	SEX: Male Female			
ADDRESS:A	PT/CONDO:	LEGAL MARITAL STATUS			
		Single Widowed			
CITY:					
STATE:ZIP C	ODE:	Limited Divorce/ Legal Separation			
Home Phone: ()					
	I IVI Y	STATUS:			
Work Phone: ()		ryland State Retirement System Retiree or			
Cell Phone: ()		Surviving Beneficiary. Please indicate relationship:			
	Ont	tional Retirement Plan (ORP) Retiree			
Personal E-mail:		., TIAA-CREF) or Surviving Beneficiary. Please indicate			
Work E-mail:		relationship:			
Social Security Number: / / /	Sate	ellite Retiree			
		ency Name: or Surviving Beneficiary. Please indicate			
Date of Birth: / / /		relationship:			
STATUS & ENROLLMENT/C	CHANGE ACT	ION REQUESTED			
New Retiree	Change in Family State	us (See Benefits Guide for documentation requirements)			
Effective Date:		60 days of the date of the qualifying event.			
Last Day of State Employment:	Add Dependent beca				
Disability Retirement? Yes No	Marriage Date:				
New Beneficiary of Deceased Retiree	Birth/Adoption/Appointed Permanent Legal Guardian				
Name of Deceased:	Date:				
Date of Retiree's Death:	Remove Dependent	bassues of			
	-	Divorce/Legal Separation Date:			
Medicare Eligibility (Complete Medicare Information Section, page 3)		(Attach copy of Death Certificate)			
Open Enrollment - Effective January 1st		ger eligible Date:			
Cancel all Coverage in all Plans/Reason:	_	ger engione Bute.			
Other Reason:					
COMPLETED AND SIGNED ENROLLMENT FO	RMS MAY BE MAIL	ED OR HAND-DELIVERED TO:			
	Benefits Division	EBD Use Only:			
301 W. Prestor	n Street, Room 510	Reviewed			

Hours of Operation: Monday - Friday 8:30 a.m. - 4:30 p.m.

Baltimore, Maryland 21201

Processed Audited

Phone: 410-767-4775 or 1-800-307-8283 / Fax: 410-333-5191 / Email: EBD.mail@maryland.gov

ENROLLMENT FOR JANUARY 2014-DECEMBER 2014

DEPENDENT INFORMATION PLEASE PRINT

Dependent means your eligible: (a) spouse, or (b) 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 FORM MUST BE FILLED OUT COMPLETELY INCLUDING SOCIAL SECURITY NUMBERS, 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 SELECT AND CLAIMS ARE PAID PROPERLY. 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	LAST NAME	FIRST NAME, MI	SEX BA	DATE OF BIRTH	DATE OF BIRTH RELATIONSHIP	ELIGIBLE FOR MEDICARE (Y/N)	SOCIAL SECURITY NO.	(✓) COVER THIS DEPENDENT FOR:		
C	LAST IVAILE	PINSI NAME, MI	SLA	MM/DD/YYYY	RELATIONSIIII	(Y/N)		MEDICAL	DRUG	DENTAL

Special Notifications:

- Tax-qualified dependent children 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 income taxes if the State subsidizes dependent coverage for individuals who are not your tax dependents. Refer to the Benefits Guide for details.

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Medical Benefits - A Beneficiary is considered a "Retiree"

Choose One Option:

New Enrollment Change in 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 #4 if no one covered is eligible for Medicare Parts A & B

- 1. Retiree Only, No Medicare
- 2. Retiree & One Child, No Medicare
- 3. Retiree & Spouse, No Medicare
- 4. Retiree & Two or More, No Medicare

Choose One Medical Plan:

Aetna EPO Aetna POS

CareFirst BC/BS EPO CareFirst BC/BS POS CareFirst BC/BS PPO UnitedHealthcare EPO UnitedHealthcare POS UnitedHealthcare PPO

Choose from #5 to #11 if anyone covered is eligible for Medicare (the Retiree must be one of the individuals covered):

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

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.

Medicare Information - A Beneficiary is considered a "Retiree"

Medicare information must be provided for anyone covered under your Retiree enrollment 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 (Physician) will be responsible for paying the amount that Medicare would have paid (approximately 80% of all eligible services). Medicare rules for End Stage Renal Disease (ESRD) differ; see Benefits Guide for more information.

NAMES OF INDIVIDUAL(S) 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	MEDICA Age 65	ARE DUE Disabled	E TO (<): ESRD
Retiree							
Spouse							
Child							

Prescription Drug Coverage - A Beneficiary is considered a "Retiree"

Choose One Option: Choose One Coverage Level:

New enrollment Retiree Only

Add or Remove a Dependent Retiree & One child

I do not want Prescription Drug Coverage Retiree & Spouse

Cancel current Prescription Drug Coverage Retiree & Two or More People

Dental Coverage - A Beneficiary is considered a "Retiree"

Choose One Option: Choose One Coverage Level: Choose One Plan:

New enrollment Retiree Only United Concordia DPPO
Change in plan Retiree & One Child United Concordia DHMO

Add or remove a dependent Retiree & Spouse

I do not want Dental Coverage Retiree & Two or More People For DHMO Plan: Once enrolled, you must contact the plan to select a primary Dentist

Cancel current Dental Coverage office. Call plan or see plan website for details.

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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 Decrease Life Insurance Cancel Life Insurance	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 \$ \Boxedom					
SPOUSE	Choose One Option: Continue Spouse Life Insurance Decrease Spouse Life Insurance Cancel Spouse Life Insurance	Choose a coverage amount in increments of \$5,000 for your spouse to 1/2 of the amount chosen for yourself (must be equal to or less that current coverage): Fill in the amount of Benefit \$ \q					
CHILDREN	Choose One Option: Continue Child Life Insurance benefits Decrease Child Life Insurance benefits Cancel Child Life Insurance benefits	Choose a coverage amount in increments of \$5,000 for your and/or your spouse'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 reduction	ns in Life Insurance coverage beginning at age 65.					
Retiree Sign	ature						
choices I have m necessary deduct be tax consequen Plan Administrat information perta form is complete Insurer Reporting payments with of website for more Open Enrollmen I understand th have chosen in th to modify any of will continue bey I certify that I a to which I or my benefits, coverag dependents on m obtain benefits to premiums which I certify that I retiree's membe Other than Medic insurance? N	ade. I agree to make any premium payments may ions. I understand that to the extent the State is been to me if I cover dependents who are not more for the proper administration of my coverage ining to me or my dependents to the benefit possible, accurate, and in accordance with the Department of Law 42 U.S.C. 1395y(b)(7) requires group has ther insurance benefits. Please refer to our Not detailed information. I understand that I cannot period or as a result of a qualifying event at the Benefit Program offered by the State is mis enrollment are only in effect for January 20 and December 31, 2014. The benefits provided and gives no assurances and any dependents listed for coverage are eligible dependents are not entitled is considered frauge levels and deductions. I further understand benefits application, or fail to take the necess of which I am not entitled, my benefits will be dependent and inappropriately and may face the neither I nor my covered dependents are covership for any coverage for which I or they are and your State of Maryland benefits, do you have been paid inappropriately and may face the necessary of the state of Maryland benefits, do you have been paid inappropriately and may face the necessary of the state of Maryland benefits, do you have been paid inappropriately and may face the necessary of the state of Maryland benefits, do you have been paid inappropriately and may face the necessary of the state of Maryland benefits, do you have been paid inappropriately and may face the necessary of the state of Maryland benefits, do you have been paid inappropriately and may face the necessary of the state of Maryland benefits, do you have been paid inappropriately and may face the necessary of the state of Maryland benefits, do you have been paid in the state of Maryland benefits, do you have been paid in the state of th	subject to modifications and changes and that the benefits I 014-December 2014. The State of Maryland reserves the right s, expressed or implied, that any coverage obtained hereunder gible for coverage. I understand that enrollment in benefits d. In all cases I am responsible for the accuracy of my I that if I willfully misrepresent the eligibility of myself or my sary action to remove ineligible dependents, or in any way cancelled. I may be required to repay any claims and insurance criminal investigation and prosecution.					
Policy Number:_	and Ef	fective Date:					

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.

Date

Retiree/Beneficiary Signature