

RETURN COMPLETED Baltimore County Public Schools, Office of Employee Benefits, Leaves and Retirements
FORM TO: 1946 Greenspring Drive, Suite N, Timonium, MD 21093 • Phone: (410) 887-8943 • Fax: (410) 887-8950

1. TYPE OF REQUEST- This application is for one of the following:

New hire (Effective ___/___/___) Open Enrollment Change in status (Check below) (Effective ___/___/___)

If you have experienced a change in status outside of Open Enrollment, complete this section

Add Dependent(s)**:	Date of event: ___/___/___	Remove dependent(s)**:	Reason for termination:	Date of event: ___/___/___
<input type="checkbox"/> Marriage	___/___/___	<input type="checkbox"/> Spouse	<input type="checkbox"/> Death	___/___/___
<input type="checkbox"/> Birth of child	___/___/___	<input type="checkbox"/> Child/children	<input type="checkbox"/> Divorce	___/___/___
<input type="checkbox"/> Adoption of child	___/___/___		<input type="checkbox"/> Child reached age limit	___/___/___
<input type="checkbox"/> Other (explain) _____	___/___/___		<input type="checkbox"/> Other (explain) _____	___/___/___

****Must submit request within 30 days of event and attach supporting documentation**

2. SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	MAIDEN/FORMER NAME (if Applicable)	SOCIAL SECURITY NUMBER
STREET ADDRESS				APT. NO.
CITY				STATE
SEX				DATE OF BIRTH
<input type="checkbox"/> M <input type="checkbox"/> F	PHONE NO.			MARITAL STATUS
			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner	Date of Event
STREET ADDRESS			APT. NO.	DATE OF HIRE (New Hire Only)
CITY			STATE	ZIP

3. ELECTION OF BENEFITS - Refer to the Benefits Enrollment and Reference Guide for Details.

<p>MEDICAL PLAN OPTIONS: Check a plan <u>and</u> a level of coverage</p> <p><input type="checkbox"/> CareFirst BlueCross BlueShield Triple Choice/MPOS (not available new hires)</p> <p><input type="checkbox"/> Kaiser Permanente HMO (MD only)</p> <p><input type="checkbox"/> CIGNA OAPIN</p> <p><input type="checkbox"/> CIGNA OAP</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Parent & Child (children for Kaiser only)</p> <p><input type="checkbox"/> Two Adults</p> <p><input type="checkbox"/> Family</p> <p><input type="checkbox"/> I cancel/waive medical coverage</p> <p>PERSONAL ACCIDENT INSURANCE:</p> <p><input type="checkbox"/> Employee Benefit Amount \$____,000</p> <p><input type="checkbox"/> Spouse (circle one): 50% or 100%</p> <p><input type="checkbox"/> Children: 10%</p> <p><input type="checkbox"/> I cancel/waive PAI insurance</p>	<p>VISION INSURANCE: CareFirst Davis Plan - Employee coverage is free if your FTE is .500 or greater</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Family</p> <p><input type="checkbox"/> I cancel/waive family vision insurance</p> <p>LONG TERM DISABILITY:</p> <p><input type="checkbox"/> I elect LTD coverage</p> <p><input type="checkbox"/> I cancel/waive LTD insurance</p> <p>CANCER & INTENSIVE CARE INSURANCE</p> <p><input type="checkbox"/> I cancel cancer insurance</p>	<p>DENTAL PLAN OPTIONS: Check a plan <u>and</u> level of coverage</p> <p><input type="checkbox"/> CareFirst BlueCross BlueShield Regional Dental PPO</p> <p><input type="checkbox"/> CareFirst BlueCross BlueShield Regional Dental Traditional</p> <p><input type="checkbox"/> CIGNA Dental DHMO</p> <p>You <u>must</u> select a CIGNA dentist in section 4 below.</p> <p><input type="checkbox"/> Individual <input type="checkbox"/> Parent & Child (children for CIGNA only) <input type="checkbox"/> Two Adults <input type="checkbox"/> Family</p> <p><input type="checkbox"/> I cancel/waive dental coverage</p> <p>OPTIONAL LIFE INSURANCE:</p> <p><input type="checkbox"/> I cancel/waive optional life insurance</p>
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4. COVERED EMPLOYEE AND DEPENDENT(S) INFORMATION

PLEASE LIST ALL MEMBERS TO BE COVERED. If you are adding or removing coverage for a dependent, please check the appropriate box below and complete all of the information. If Triple Choice/MPOS indicate primary care physician or medical center and I.D. #.

LAST NAME	FIRST	M.I.	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PRIMARY CARE PHYSICIAN INFO	EXISTING PATIENT OF PCP?	CIGNA DHMO Facility Number
			EMPLOYEE/APPLICANT				NAME:	<input type="checkbox"/> Y <input type="checkbox"/> N	
			SPOUSE/PARTNER <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				NAME:	<input type="checkbox"/> Y <input type="checkbox"/> N	
			CHILD <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				NAME:	<input type="checkbox"/> Y <input type="checkbox"/> N	
			CHILD <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				NAME:	<input type="checkbox"/> Y <input type="checkbox"/> N	
			CHILD <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				NAME:	<input type="checkbox"/> Y <input type="checkbox"/> N	
			CHILD <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				NAME:	<input type="checkbox"/> Y <input type="checkbox"/> N	

If you have any questions concerning the benefits and services that are provided by or excluded under the agreement, please contact the applicable plan's membership services representative before signing the application form. I hereby apply for myself and any dependents listed on this application for the coverage indicated and authorize my employer to deduct from my earnings the amount required to participate in the elected plans. I understand that the elections that I make on this form will remain in effect for the entire Plan Year, unless I am permitted to change them during the Plan Year under special rules contained in the plan that apply only in very limited situations. If I do not complete and file a new enrollment form during the next annual enrollment period, the elections I make on this form will continue in effect indefinitely until changed by me during an annual enrollment period or in connection with the special rules discussed above. I also understand that the elections I make on this form are subject to modification by the Employer to insure that the Plan complies with applicable laws or to reflect increases in the cost of the elected coverage(s) that occur during the Plan Year. I hereby consent, for myself and for all individuals covered by the Plan through me, to any investigations or inquiries into medical condition that are deemed necessary or appropriate by the Plan Administrator and to any disclosures of medical records by anyone deemed necessary or appropriate by the Plan Administrator. I have carefully read this application and agree to its terms. The statements are true and complete and are representations made to induce the issuance of the subscription agreement(s) for which I have applied.

EMPLOYEE'S SIGNATURE _____ DATE _____

RETAIN A COPY FOR YOUR RECORDS

* If you are retiring on or before 9/1 do not complete this form to make enrollment changes. Contact the Office of Benefits, Leaves & Retirements.