BALTIMORE COUNTY PUBLIC SCHOOLS • FLEXIBLE BENEFITS ENROLLMENT/CHANGE APPLICATION 2009-2010
ACTIVE EMPLOYEES (Please print or type)*

RETURN COMPLETED FORM TO: **Baltimore County Public Schools, Office of Employee Benefits**
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:
☐ Marriage	___/___/___	☐ Spouse	☐ Death	___/___/___
☐ Birth of child	___/___/___	☐ Child/children	☐ Divorce	___/___/___
☐ Adoption of child	___/___/___		☐ Child reached age limit	___/___/___
☐ Other (explain) ______________________	___/___/___		☐ Child no longer student	___/___/___
			☐ 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.	DATE OF HIRE (New Hire Only) ___ ___ / ___ ___ / ___ ___

CITY	STATE	ZIP

SEX	DATE OF BIRTH	PHONE NO.	MARITAL STATUS	Date of Event
☐ M ☐ F	___ ___ / ___ ___ / ___ ___	( ) -	☐ Single ☐ Married ☐ Partner	___/___/___

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

MEDICAL PLAN OPTIONS:
Check a plan and a level of coverage
☐ CareFirst BlueCross BlueShield Triple Choice/MPOS
☐ Kaiser Permanente HMO (MD only)
☐ Keystone Health Plan Central HMO (PA residents only)
☐ Individual
☐ Parent & Child (children for Kaiser only)
☐ Two Adults
☐ Family
☐ I cancel/waive medical coverage

PERSONAL ACCIDENT INSURANCE:
☐ Employee Benefit Amount $_____,000
☐ Spouse (circle one): 50% or 100%
☐ Children: 10%
☐ I cancel/waive PAI insurance

VISION INSURANCE:
Vision Service Plan (VSP)- Employee coverage is free if your FTE is .500 or greater
☐ Individual
☐ Family - I understand that my election will remain in effect until 8/31/11.
☐ I cancel/waive family vision insurance

LONG TERM DISABILITY:
☐ I elect LTD coverage
☐ I cancel/waive LTD insurance

CANCER & INTENSIVE CARE INSURANCE
☐ I cancel cancer insurance
CONSECO Coverage not available for new hires.

DENTAL PLAN OPTIONS:
Check a plan and level of coverage
☐ CareFirst BlueCross BlueShield Regional Dental PPO
☐ CareFirst BlueCross BlueShield Regional Dental Traditional
☐ CIGNA Dental DHMO
You must select a dentist in section 4 below
☐ Parent & Child (children for CIGNA only)
☐ Family ☐ Two Adults ☐ I cancel/waive dental coverage

OPTIONAL LIFE INSURANCE:
☐ I cancel/waive optional life insurance

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 or HMO 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 #
	EMPLOYEE/ APPLICANT				NAME:	☐ Y ☐ N	
	SPOUSE/ PARTNER ☐ ADD ☐ REMOVE				NAME:	☐ Y ☐ N	
	CHILD ☐ ADD ☐ REMOVE				NAME:	☐ Y ☐ N	
	CHILD ☐ ADD ☐ REMOVE				NAME:	☐ Y ☐ N	
	CHILD ☐ ADD ☐ REMOVE				NAME:	☐ Y ☐ N	
	CHILD ☐ ADD ☐ REMOVE				NAME:	☐ Y ☐ N	

DEPENDENT INFORMATION

DISABLED? ☐ YES ☐ NO NAME: ________________________________ DATE OF DISABILITY _ _ / _ _ / _ _
FULL TIME COLLEGE STUDENT(S) ☐ YES ☐ NO NAME: ________________________________ SCHOOL NAME ______________________ DATE OF GRADUATION _ _ / _ _ / _ _
FULL TIME COLLEGE STUDENT(S) ☐ YES ☐ NO NAME: ________________________________ SCHOOL NAME ______________________ DATE OF GRADUATION _ _ / _ _ / _ _

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 & Retirement.