

**BALTIMORE COUNTY PUBLIC SCHOOLS**  
**RETIREE BENEFITS ENROLLMENT/CHANGE APPLICATION** (Please print or type)

**RETURN COMPLETED FORM TO: Baltimore County Public Schools, Office of Retiree Benefits**  
**1946 Greenspring Drive, Suite N, Timonium, MD 21093 • Fax: (410) 887-8950**

**1. SUBSCRIBER INFORMATION**

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER		
					____/____/____
STREET ADDRESS					APT.NO.
CITY			STATE		ZIP
SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH ____/____/____	HOME PHONE NO. ( ) -	ALTERNATE PHONE NO. ( ) -		MARITAL STATUS Date of Event <input type="checkbox"/> Single <input type="checkbox"/> Married ____/____/____

**2. ELECTION OF BENEFITS**

<b>MEDICAL PLAN OPTIONS:</b> Check a plan <u>and</u> a level of coverage <input type="checkbox"/> CareFirst BlueCross BlueShield Triple Choice/MPOS <input type="checkbox"/> Kaiser Permanente HMO* (MD only) <input type="checkbox"/> Keystone Health Plan Central HMO (PA residents only) <input type="checkbox"/> Individual <input type="checkbox"/> Parent & child (*children for Kaiser only) <input type="checkbox"/> Two Adults <input type="checkbox"/> Family <input type="checkbox"/> I cancel/waive medical coverage	<b>VISION INSURANCE:</b> Vision Service Plan (VSP) <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Cancel/waive family vision insurance	<b>DENTAL PLAN OPTIONS:</b> Check a plan <u>and</u> level of coverage <input type="checkbox"/> CareFirst BlueCross BlueShield Regional Dental PPO <input type="checkbox"/> CareFirst BlueCross BlueShield Regional Dental Traditional <input type="checkbox"/> CIGNA Dental DHMO (you must select Dentist in Section 4 below) <input type="checkbox"/> Individual <input type="checkbox"/> Parent & child <input type="checkbox"/> Two Adults <input type="checkbox"/> Family <input type="checkbox"/> I cancel/waive dental coverage
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**3. CHANGE IN STATUS (if applicable)**

If you have experienced a change in status, complete this section.

<b>Add Dependent(s)*:</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Other (explain) _____ *Attach supporting documentation	<b>Date of event:</b> ____/____/____ ____/____/____ ____/____/____ ____/____/____	<b>Remove dependent(s):</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Child/children *Attach supporting documentation	<b>Reason for termination:</b> <input type="checkbox"/> Death* <input type="checkbox"/> Divorce* <input type="checkbox"/> Child reached age limit <input type="checkbox"/> Child no longer student <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> Other (explain) _____	<b>Date of event:</b> ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____
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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 or HMO indicate primary care physician or medical center.

LAST NAME	FIRST	M.I.	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PRIMARY CARE PHYSICIAN INFO	CIGNA DHMO FACILITY NUMBER
			EMPLOYEE/APPLICANT				LAST NAME: _____ FIRST NAME: _____	
			TWO ADULTS <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				LAST NAME: _____ FIRST NAME: _____	
			CHILD <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				LAST NAME: _____ FIRST NAME: _____	
			CHILD <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				LAST NAME: _____ FIRST NAME: _____	
			CHILD <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				LAST NAME: _____ FIRST NAME: _____	
			CHILD <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE				LAST NAME: _____ FIRST NAME: _____	

**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.

RETIREE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**RETAIN A COPY FOR YOUR RECORDS**