

**BALTIMORE COUNTY PUBLIC SCHOOLS
RETIREE BENEFITS ENROLLMENT/CHANGE APPLICATION**

PLEASE PRINT

**RETURN COMPLETED FORM TO: Baltimore County Public Schools, Office of Retiree Benefits
1946 Greenspring Drive, Suite N, Timonium, MD 21093 • Phone: (410) 887-8943 • 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. () -		ALTERNATIVE PHONE NO. () -		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	Date of Event _ / _ / _

2. ELECTION OF BENEFITS

<p>MEDICAL PLAN OPTIONS: Check a plan and a level of coverage</p> <p><input type="checkbox"/> CareFirst BlueCross BlueShield Triple Choice/MPOS</p> <p><input type="checkbox"/> Kaiser Permanente HMO* (MD only)</p> <p><input type="checkbox"/> CIGNA OAPIN – in network only</p> <p><input type="checkbox"/> CIGNA OAP – in/out of network</p> <p><input type="checkbox"/> CIGNA Medicare Surround</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>VISION INSURANCE: CareFirst Davis Vision Plan</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>DENTAL PLAN OPTIONS: Check a plan and a 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 (you must select a CIGNA DHMO Dentist in Section 4 below)</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Parent & Child (*children for CIGNA 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>
--	---	---

3. CHANGE IN STATUS (if applicable)

If you have experienced a change in status, complete this section and attach supporting documentation (birth/adoption certificate, marriage certificate, divorce decree etc.)

<p>Add Dependent(s):</p> <p><input type="checkbox"/> Marriage Date of Event: ___/___/___</p> <p><input type="checkbox"/> Birth of Child ___/___/___</p> <p><input type="checkbox"/> Adoption of Child ___/___/___</p> <p><input type="checkbox"/> Other (explain) ___/___/___</p>	<p>Remove dependents:</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Child/children</p>	<p>Reason for termination:</p> <p><input type="checkbox"/> Death</p> <p><input type="checkbox"/> Divorce</p> <p><input type="checkbox"/> Child reached age limit</p> <p><input type="checkbox"/> Other (explain) ___/___/___</p>
---	---	--

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 NAME	M.I.	RELATIONSHIP	SEX	DATE of BIRTH	SOCIAL SECURITY NUMBER	PRIMARY CARE PHYSICIAN (PCP) 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:	

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