STATE OF MARYLAND
DIRECT PAY ENROLLMENT FORM
JANUARY 2020-DECEMBER 2020 HEALTH BENEFITS

PERSONAL DATA *PLEASE PRINT CLEARLY*

EMPLOYEE/FORMER EMPLOYEE/RETIREE INFORMATION

Name: _____
LAST FIRST MI

Address: _____ **Apt/Condo:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (__ __ __) __ __ __ - __ __ __ __

Work Phone: (__ __ __) __ __ __ - __ __ __ __

Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Personal E-mail: _____

Work E-mail: _____

W#: W __ __ __ __ __ __ __ __

Date of Birth: __ __/__ __/__ __ __ __
MM /DD/ YYYY

Sex: ○ **Male** ○ **Female**

LEGAL MARITAL STATUS:
○ Single ○ Widowed
○ Married ○ Divorced
○ Limited Divorce/Legal Separation

FORMER DEPENDENT INFORMATION (if different from employee's information)

Name: _____
LAST FIRST MI

Address: _____ **Apt/Condo:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (__ __ __) __ __ __ - __ __ __ __

Work Phone: (__ __ __) __ __ __ - __ __ __ __

Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Personal E-mail: _____

Work E-mail: _____

Social Security Number: __ __ __ /__ __ / __ __ __ __

Date of Birth: __ __/__ __/__ __ __ __
MM /DD/ YYYY

Sex: ○ **Male** ○ **Female**

LEGAL MARITAL STATUS:
○ Single ○ Widowed
○ Married ○ Divorced
○ Limited Divorce/Legal Separation

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

○ **COBRA** Date of Qualifying Event: _____

Are you on Medicare? ○ Yes ○ No

○ **Part-Time** Employee *(Less than 50%)*

○ **LAW-MILITARY** (Unpaid Leave of Absence - Military)

○ Training ○ Active Duty

Effective Date of LAW-MILITARY: _____

End Date of LAW-MILITARY: _____
(Military orders must be submitted with this form)

○ **LAW – PERSONAL** (Unpaid Leave of Absence - Personal)

Effective Date of LAW-PERSONAL: _____

End Date of LAW-PERSONAL: _____
(May not exceed 2 years)

○ **LAW-OJI** (Unpaid Leave of Absence – On the Job Injury)

Effective Date of LAW-OJI: _____

End Date of LAW-OJI: _____
(May not exceed 2 years - proof of payment from IWIF or worker's comp required.)

○ Open Enrollment - Effective January 1st

○ New Enrollment

○ Cancel all Coverage in all Plans/Reason: _____

Change in Family Status (See Benefits Guide for documentation requirements)
Note: Request must be made within 60 days of the date of the qualifying event

○ **Add dependent** because of:

○ Marriage Date: _____

○ Birth/Adoption/Appointed Permanent Legal Guardian

Date: _____

○ Other/Reason: _____

○ **Remove dependent** because of:

○ Divorce/Limited Divorce/Legal Separation Date: _____

○ Death Date _____ ***(Attach copy of Death Certificate)***

○ Dependent no longer eligible Date: _____

Reason: _____

○ Other: _____

COMPLETED AND SIGNED ENROLLMENT FORMS MAY BE MAILED OR HAND-DELIVERED TO:
NOTE: PART-TIME AND LAW FORMS MUST BE SIGNED BY THE AGENCY BENEFITS COORDINATOR

Employee Benefits Division
Enrollment Unit
301 W. Preston Street, Room 510
Baltimore, Maryland 21201

Hours of Operations: Monday - Friday 8:30 a.m. - 4:30 p.m.
Phone: 410-767-4775 or 1-800-307-8283 / Fax: 410-333-5191 /
Email: enrollment.ebd@maryland.gov

EBD Use Only:
____ Reviewed
____ Processed
____ Audited

Health benefits information and forms are available on our website: www.dbm.maryland.gov/benefits

ENROLLMENT FOR JANUARY 2020-DECEMBER 2020

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 NUMBER AND DATE OF BIRTH) TO ENSURE YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECT.** 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 C	LAST NAME	FIRST NAME, MI	SEX	DATE OF BIRTH MM/DD/YYYY	RELATIONSHIP	SOCIAL SECURITY NO.	(✓) COVER THIS DEPENDENT FOR:		
							MEDICAL	DRUG	DENTAL
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
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							☐	☐	☐
							☐	☐	☐

Special Notifications:

- Biological, adopted and step children age 26 and over must have become disabled prior to reaching age 26 in order to be eligible for continued coverage.
- Grandchildren, step grandchildren, legal wards and other child relatives age 25 and over must have become disabled prior to reaching age 25 in order to be eligible for continued coverage.

ENROLLMENT FOR JANUARY 2020-DECEMBER 2020

COBRA - Consolidated Omnibus Budget Reconciliation Act and Other Continuation Coverage

You and your eligible dependents may continue health coverage if the loss of coverage is due to one of the following qualifying events:

Mark the event that applies to you:

QUALIFYING EVENT	MAXIMUM PERIOD OF TIME ELIGIBLE FOR CONTINUATION*
○ 1. Terminated employee (other than for gross misconduct)	18 months or until eligible for group coverage through another source including Medicare
○ 2. Resigned	18 months or until eligible for group coverage through another source including Medicare
○ 3. Laid off employee	18 months or until eligible for group coverage through another source including Medicare
○ 4. Employee whose hours have been reduced	18 months or until eligible for group coverage through another source including Medicare
○ 5. Divorce or legally separated spouse of a current State employee/retiree	Indefinitely or at the time of remarriage or until eligible for group coverage through another source including Medicare

Mark the event, if different, that applies to your dependent:

QUALIFYING EVENT	MAXIMUM PERIOD OF TIME ELIGIBLE FOR CONTINUATION*
○ 6. Spouse or child of a State employee/retiree who has elected Medicare as the only coverage and the spouse or child is not eligible for Medicare	36 months or until eligible for group coverage through another source including Medicare
○ 7. Previously dependent child of an employee/ retiree who is no longer eligible by reason of age or death of employee	36 months or until eligible for group coverage through another source including Medicare
○ 8. Death of a State employee/retiree	36 months or until eligible for group coverage through another source including Medicare

**** The period of continuation of coverage is the number of months listed, or until eligible for coverage elsewhere, whichever is less.***

Medical Benefits - Available to COBRA, LAW, Part-Time

CHOOSE ONE OPTION:
- ○ New Enrollment
- ○ Change in plan
- ○ Addition or removal of dependent
- ○ No, I do not want to enroll in this benefit
- ○ Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- ○ Individual Only
- ○ Individual & One Child
- ○ Individual & Spouse
- ○ Individual & Family
- ○ End Stage Renal (ESRD) (Complete Medicare Information below)

CHOOSE ONE MEDICAL PLAN:
- ○ CareFirst BC/BS EPO
- ○ CareFirst BC/BS PPO
- ○ Kaiser IHM*
- ○ UnitedHealthcare EPO
- ○ UnitedHealthcare PPO

Bargaining Unit I members only (SLEOLA) on LAW:
- ○ CareFirst BC/BS EPO Mod-I
- ○ CareFirst BC/BS POS Mod-I
- ○ CareFirst BC/BS PPO Mod-I

****Members and/or dependents eligible for Medicare due to age, disability, or End Stage Renal Disease (ESRD) are not eligible to enroll in the Kaiser medical plan.***

NOTE: Vision and Mental Health/Substance Abuse benefits are included if enrolled in a medical plan. Medical plans do not include Prescription Drug or Dental coverage. Separate selections are required. If you or a dependent have Medicare, please write in name, Medicare number, and effective date of Medicare coverage.

NAMES OF INDIVIDUALS 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	MEDICARE DUE TO (✓): Age 65	Disabled	ESRD
Employee					☐	☐	☐
Spouse					☐	☐	☐
Child					☐	☐	☐
Child					☐	☐	☐

Prescription Drug Coverage - Available to COBRA, LAW, Part-Time

CHOOSE ONE OPTION:
- ○ New enrollment
- ○ Addition or removal of dependent
- ○ No, I do not want to enroll in this benefit
- ○ Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- ○ Individual Only
- ○ Individual & One Child
- ○ Individual & Spouse
- ○ Individual & Family

Dental Coverage - Available to COBRA, LAW, Part-Time

CHOOSE ONE OPTION:
- ○ New enrollment
- ○ Change in plan
- ○ Addition or removal of dependent
- ○ No, I do not want to enroll in this benefit
- ○ Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- ○ Individual Only
- ○ Individual & One Child
- ○ Individual & Spouse
- ○ Individual & Family

CHOOSE ONE DENTAL PLAN:
- ○ United Concordia DPPO
- ○ Delta Dental DHMO

For the DHMO Plan: You must select a primary Dentist office once enrolled. Call plan or see plan website for details.

Accidental Death and Dismemberment Benefits - Available to LAW/Part-Time

CHOOSE ONE OPTION:
- ○ New enrollment
- ○ Change of benefit amount
- ○ Addition or removal of dependent
- ○ No, I do not want to enroll in this benefit
- ○ Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- ○ Individual Only coverage
- ○ Family coverage

CHOOSE ONE BENEFIT AMOUNT:
- ○ $100,000
- ○ $200,000
- ○ $300,000

Flexible Spending Account - Healthcare - Available to COBRA and LAW

***For Employees Who Had Flexible Spending Accounts During Active Status during the January 2020-December 2020 plan year.**

THIS IS NOT A PRE-TAX BENEFIT WHILE IN DIRECT PAY STATUS AND SERVICES MUST BE INCURRED BY MARCH 15, 2021.

Healthcare Spending Account

- ○ I want to continue my Healthcare Spending Account for January 2020-December 2020. **Note:** COBRA enrollees will be billed for the same total deduction amount as an active employee plus a 2% fee on a post-tax basis.
- ○ Cancel my Healthcare Spending Account. Expenses incurred prior to the cancellation date may be reimbursed up to the limit of your Healthcare FSA.

ENROLLMENT FOR JANUARY 2020-DECEMBER 2020

Life Insurance - Available to LAW/Part-Time

APPLICANT LIFE INSURANCE

- ○ Yes, I want to enroll as a new enrollee in Life Insurance.
- ○ Yes, I want to continue my current level of coverage.
- ○ Yes, I want to continue my Life Insurance, but at a different amount.
- ○ No, I do not want to enroll in this benefit.
- ○ Cancel all Life Insurance (applicant and dependent).

Please select a benefit amount in increments of $10,000, up to $300,000:
STOP: If you choose an amount greater than $50,000, you must fill out a Life Insurance Evidence of Insurability form. The life insurance vendor will contact you about completing this form. Amount over $50,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the Benefit Amount

$ ☐☐0,000 ***Coverage available in increments of $10,000 only***

DEPENDENT LIFE INSURANCE

Choose a coverage amount in increments of $5,000 up to 1/2 of the amount chosen for yourself, up to $150,000.
STOP: If you choose an amount greater than $25,000, you must fill out a Life Insurance Evidence of Insurability form. The life insurance vendor will contact you about completing this form. Amount over $25,000 will not be effective until we receive approval from our life insurance carrier.

Life Insurance on Spouse

- ○ Yes, I want Life Insurance for my spouse.
- ○ Yes, I want to continue my spouse's Life Insurance
- ○ Yes, I want to continue my spouse's Life Insurance, but at a different amount.
- ○ No, I do not want to enroll in this benefit.
- ○ Cancel Life Insurance on my spouse.

Please fill in the Benefit amount: $ ☐☐☐,000

Life Insurance on Child(ren)

- ○ Yes, I want Life Insurance on my child(ren).
- ○ Yes, I want to continue my child(ren)'s Life Insurance
- ○ Yes, I want to continue my child(ren)'s Life Insurance, but at a different amount.
- ○ No, I do not want to enroll in this benefit.
- ○ Cancel Life Insurance on child(ren)

Please fill in the Benefit amount: $ ☐☐☐,000

LAW - Long Term Leave Without Pay Due to a Job-Related Injury or Military Leave

If the long term LAW is the result of a job-related accident or injury (LAW-OJI), the State will pay the State portion and the employee will continue to pay the Active employee portion. A copy of the proof of IWIF or worker's compensation approval for payment must be submitted with this enrollment form. If the long term LAW is due to any other reason, the employee must pay 100 percent of the premium. In either case the employee will be billed directly by the Department of Budget & Management for the amount due.

AGENCY BENEFITS COORDINATOR - PLEASE PRINT THE FOLLOWING:

A. _____ is on Approved Leave of Absence-On the Job Injury effective _____
Employee s Name — Date

B. Anticipated date of return to work: _____
Date

C. Is this an initial LAW-OJI? Yes No **OR** Is this an extension of a previous Long Term LAW-OJI? ○ Yes ○ No

FISCAL OFFICER - PLEASE PRINT THE FOLLOWING:

Appropriation Code: ___ (Agency) ___ ___ ___ ___ (PCA) ___ ___ ___ (TC) ___ ___ ___ ___ (R Stars Sub Object)

_____ Fiscal Officer Name & Phone Number

_____ Fiscal Officer Signature

Applicant and Agency Signatures

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 representative before signing this application.

Please enroll me for the benefits indicated on this form. I understand the benefits and limitations provided by the various plans. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget & Management regulations. The Mandatory Insurer Reporting Law 42 U.S.C. 1395y(b)(7) requires group health plans to report SSNs in order for Medicare to coordinate payments with other insurance benefits. Please refer to our Notice of Privacy Practices in the Benefit Guide and on our website for more detailed information. **I understand that I cannot cancel or change my enrollment elections except during an Open Enrollment period or as the result of a qualifying change in family status permitted by COMAR 17.04.13.04 and IRS Section 125.**

I understand that the Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen on this enrollment form are only in effect for the current plan year. The State of Maryland reserves the right to modify any benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond the end of the current plan year. **I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for any coverage for which I or they are enrolled on this form.**

I certify that I and any dependents listed for coverage are eligible for coverage. I understand that enrollment in benefits to which I am or my dependents are not entitled is considered fraud. **In all cases I am responsible for the accuracy of my benefits, coverage levels and premiums.** I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my benefits application, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be canceled, I will be required to repay any claims and insurance premiums, and I may face criminal investigation and prosecution.

I further solemnly affirm under the penalties of perjury under applicable state laws that any dependent information I have provided is true and accurate. I understand that willful falsification of information contained in this attestation can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the person identified as my dependent, and the termination of coverage for myself (the employee/retiree). I understand that a civil action may be brought against me for any losses, including reasonable attorney fees because of a false statement contained in this attestation, and that other serious consequences may result.

I further attest and agree that if a dependent's status changes and the dependent is no longer eligible, I will notify my Agency Benefit Coordinator or the Employee Benefits Division immediately to remove this dependent from my coverage. I also agree to provide the required documentation as outline in the current plan year's Benefits Guide to substantiate the information I have provided, and affirm that each enrolled dependent is my true tax dependent.

X _____ _____
YOUR SIGNATURE — Date

X _____ _____
AGENCY SIGNATURE - Agency Must Sign — Date

Agency Code: _____ _____ _____
Work Phone Number (Ext.) — Fax Number

Check Dist. Code: _____ _____
Agency Benefit Coordinator Email Address