



# Employee Benefit Plan Enrollment

Employee and Retiree Service Center (ERSC)  
MONTGOMERY COUNTY PUBLIC SCHOOLS  
7361 Calhoun Place, Ste. 190 • Rockville, Maryland 20855

**MCPS Form 455-20**  
**September 2009**

**INSTRUCTIONS:** Complete both sides, sign, and return the Employee and Retiree Service Center (ERSC). This form must be signed at the bottom of pages 1 and 2. **You may fax enrollment forms to 301-279-3642/301-279-3651 or e-mail an electronically signed Adobe PDF file to ERSC@mcpsmd.org. Please do not mail copies to ERSC once you have faxed or e-mailed the enrollment form. A confirmation of your requested change(s) will be sent to you. Unsigned forms will be returned to you and become your responsibility to resubmit to ERSC by the appropriate deadline.**

### SECTION I: EMPLOYEE INFORMATION—Please Print.

Name \_\_\_\_\_ Employee ID # 0 0 0 0

Last Four Digits of Social Security # \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Work Location \_\_\_\_\_ Date of Birth \_\_\_\_\_

Is your spouse or dependent(s) covered under his/her own MCPS Plan?  Yes  No  
(Please note: MCPS employees or dependents may only be covered under one MCPS plan.)

### SECTION II: ENROLLMENT INFORMATION—If your address has changed, please submit MCPS Form 445-1 with your benefit enrollment form. Benefit enrollment confirmations are sent to the address on file. Individual Two-Party Family

| A. General   | B. Drop Dependents   | C. Add Dependent(s)   | Date  |
|--|--|---|-------|
| <input type="checkbox"/> New Employee (Enroll within 60 days following employment.)  | <input type="checkbox"/> Child                               | <input type="checkbox"/> Marriage*  | _____ |
| <input type="checkbox"/> Open Enrollment   | <input type="checkbox"/> Spouse                              | <input type="checkbox"/> Birth of Child*  | _____ |
| <input type="checkbox"/> Qualifying Event<br><i>Please include applicable documentation.</i>                                   | <input type="checkbox"/> Qualified Same Sex Domestic Partner | <input type="checkbox"/> Adoption of Child*   | _____ |
| <input type="checkbox"/> Employees Returning from Leave (must re-enroll in same plan prior to leave within 60 days of return.) |  | <input type="checkbox"/> Stepchild*,**<br>(Stepchild must reside with the employee.)  | _____ |
| <input type="checkbox"/> I <b>decline/cancel</b> all benefit plan enrollment—skip to <b>Section V, Employee Life Insurance</b> |  | <input type="checkbox"/> Qualified Same Sex Domestic Partner*   | _____ |
| <input type="checkbox"/> Change of Beneficiary only—skip to <b>Section VI, Life Insurance Beneficiary Designation</b>          |  | <input type="checkbox"/> Other (Explain: _____)   | _____ |
| <input type="checkbox"/> Add/Drop Dependent (complete Sections IIB, IIC, and IV)   |  | *You must attach legal documentation (i.e., birth or marriage certificate, proof of residency, social security number, if applicable.)<br>** For add'l requirements please review the Employee Benefit Summary. |       |

### SECTION III: BENEFIT PLAN ENROLLMENT—You must make a selection in each category (A–D).

|   |   |
|---|---|
| <b>CATEGORY A (Medical Plans)—</b><br><b>PLEASE SELECT ONE (1) OF THE FOLLOWING OPTIONS</b><br><b>HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS</b><br><input type="checkbox"/> CareFirst BlueChoice<br><input type="checkbox"/> Kaiser Permanente<br><input type="checkbox"/> UnitedHealthcare Select<br><br><b>OPEN POINT-OF-SERVICE (POS) PLANS</b><br><input type="checkbox"/> CareFirst BlueChoice POS<br><input type="checkbox"/> UnitedHealthcare Select Plus POS<br><br><b>CLOSED POINT-OF-SERVICE (POS) PLAN</b><br><input type="checkbox"/> UnitedHealthcare Select Plus POS<br>(closed to employees hired after January 1, 1994)<br><br><input type="checkbox"/> I <b>decline</b> medical coverage<br><input type="checkbox"/> No change to medical plan | <b>CATEGORY B (Prescription Drug Plans)—Please select one</b><br><input type="checkbox"/> Caremark (available to all employees <b>except</b> Kaiser HMO members)<br><input type="checkbox"/> Kaiser ( <b>only</b> available to Kaiser HMO members)<br><input type="checkbox"/> I <b>decline</b> prescription drug coverage<br><input type="checkbox"/> No change to prescription drug plan<br><br><b>CATEGORY C (Dental Plans)—Please select one</b><br><input type="checkbox"/> Aetna Preferred Provider Organization (PPO)<br><input type="checkbox"/> Aetna Dental Maintenance Organization (DMO)<br>(Benefit plan participant must reside in a DMO service area.)<br><input type="checkbox"/> I <b>decline</b> dental coverage<br><input type="checkbox"/> No change to dental plan<br><br><b>CATEGORY D (Vision Plan)—Please select one</b><br><input type="checkbox"/> National Vision Administrators (NVA)<br><input type="checkbox"/> I <b>decline</b> vision coverage<br><input type="checkbox"/> No change to vision plan |
|---|---|

### SECTION IV: COVERED PARTICIPANTS—Your dependent(s).

List:  All new participant(s) **OR**  All added or dropped dependent(s). Please include a copy of a marriage certificate when adding a spouse and/or birth certificate or birth registration. Children must reside with the employee; proof of residence is determined by submitted documentation. Additional requirements are available in the Employee Benefit Summary.

| First Name | Last Name | MI | Social Security #<br>(must be included) | Date of Birth | Sex | Add/Drop  |
|------------|-----------|----|---|---------------|-----|---|
| Spouse     |           |    |   |               |     | <input type="checkbox"/> / <input type="checkbox"/> |
| Child      |           |    |   |               |     | <input type="checkbox"/> / <input type="checkbox"/> |

(continue on reverse side)

**SECTION IV: COVERED PARTICIPANTS**—Your dependent(s).

(continued)

| First Name   | Last Name | MI | Social Security #<br>(must be included) | Date of Birth | Sex | Add/<br>Drop  |
|--|-----------|----|---|---------------|-----|---|
| Child  |           |    |   |               |     | <input type="checkbox"/> / <input type="checkbox"/> |
| Child  |           |    |   |               |     | <input type="checkbox"/> / <input type="checkbox"/> |
| Qualified Same Sex Domestic Partner (QSSDP)*                                     |           |    |   |               |     |   |
|  |           |    |   |               |     | <input type="checkbox"/> / <input type="checkbox"/> |
| *The completed QSSDP affidavit should include required supporting documentation. |           |    |   |               |     |   |

**SECTION V: BASIC EMPLOYEE TERM LIFE INSURANCE**—

**Category A—New Employees** New employees who are eligible for benefits automatically receive basic term life insurance equal to two times the employee's salary

I **decline** Basic Term Life Insurance coverage

**Category B—Open Enrollment—Only need to complete if not currently enrolled**  
After providing evidence of insurability and receiving approval from the Prudential Life Insurance Co.

**Category C—Active Employees Returning from Leave (within 60 days)**

Basic Term Life Insurance

I **decline** Basic Term Life Insurance coverage

**Category D—Active Employees**

No Change  Change of Beneficiary

**SECTION VI: LIFE INSURANCE BENEFICIARY DESIGNATION**

Please check Primary or Contingent for each designated beneficiary. If neither box is checked, the named beneficiary will be deemed as a Primary Beneficiary.

**No Change**  **Change of Beneficiary**

- Benefits shall be divided equally among Primary Beneficiaries (or Contingent Beneficiaries), unless otherwise stated.
- The Contingent Beneficiary(ies) shall be entitled to life insurance benefits in the event there is no surviving Primary Beneficiary.
- If designating a Trust as a beneficiary, please provide a copy of the title, trustee, address, and signature pages of the Trust.

**Primary**  
Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
Share \_\_\_\_\_ % Relationship \_\_\_\_\_

**Primary**  **Contingent**  
Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
Share \_\_\_\_\_ % Relationship \_\_\_\_\_

**Primary**  **Contingent**  
Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
Share \_\_\_\_\_ % Relationship \_\_\_\_\_

**FOR ADDITIONAL BENEFICIARIES OR COVERED PARTICIPANTS, PLEASE ATTACH A SEPARATE SHEET OF PAPER.**

Name \_\_\_\_\_ Employee ID # 0 0 0 0

**SIGNATURE REQUIRED**

\_\_\_\_\_ *Signature* \_\_\_\_\_ *Date*