



Retiree Benefit Plan Enrollment

Employee and Retiree Service Center (ERSC)
MONTGOMERY COUNTY PUBLIC SCHOOLS
45 West Gude Drive, Suite 1200 • Rockville, Maryland 20850

MCPS Form 455-22
October 2011

INSTRUCTIONS: All new retirees must make a selection in each category. Complete both sides, sign and return to 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: RETIREE INFORMATION—Please print. 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.

Name _____ Employee ID # 0 0 0 0 _____ SSN # _____
Last 4 digits

Address _____
Street City State Zip

Home Phone # _____ E-mail _____ **Retiree Date of Birth** ____/____/____

Retirement Date ____/____/____ (new and existing retirees) **Spouse Date of Birth** ____/____/____

SECTION II: RETIREE ENROLLMENT INFORMATION

- Continuation of Benefits in Retirement (new retirees only)
- Open Enrollment
- Transfer to active spouse or/QSSDP MCPS plan
(must include MCPS Form 455-20, *Employee Benefit Plan Enrollment*)
- Re-enrollment/Qualifying Event (if coverage was canceled after 7-1-98)
- I **cancel/decline** all benefit plan enrollment—
skip to **SECTION VI, LIFE INSURANCE OPTION**
- Drop dependent(s)
- Deceased dependent—date of death ____/____/____
- Change of Beneficiary only—skip to **SECTION VII, LIFE INSURANCE BENEFICIARY DESIGNATION**

SECTION III: RETIREE LEVEL OF HEALTH COVERAGE

- Individual
- Two-Party
- Family

You must make a selection in each section. This form must be signed for selections and designations to be valid.

SECTION IV: RETIREE BENEFIT PLAN ENROLLMENT INFORMATION—You must make a selection in each category A-D. Please consult the Retiree Benefit Summary for Benefit Plan enrollment qualifications. **If you do not make a prescription drug selection, you will be defaulted to Option A. Medicare-eligible retirees (and their eligible dependents) must enroll in Medicare Parts A and B to continue coverage with MCPS. If you enroll in a private Medicare Part D plan, all MCPS prescription coverage will be cancelled.**

CATEGORY A (Medical Plans)—

PLEASE SELECT ONE (1) OF THE FOLLOWING OPTIONS

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

- CareFirst BlueChoice HMO
- Kaiser Permanente HMO
- UnitedHealthcare Select HMO

OPEN POINT-OF-SERVICE (POS) PLANS

- UnitedHealthcare Select Plus POS¹

CLOSED POINT-OF-SERVICE (POS) PLAN

- UnitedHealthcare Select Plus POS¹
(Eligibility requirements for the closed POS Plan are available in the Retiree Benefit Summary.)
- UnitedHealthcare Indemnity/Medicare Supplemental Plan
- I **decline** medical coverage
- No change to **medical plan**²

CATEGORY B (Prescription Drug Plans)—Please select one

- Caremark (available to all retirees except Kaiser HMO members)
 - Option A Option B
- Kaiser (**only** available to Kaiser HMO members)
- I **decline** prescription drug coverage
- No change to **prescription drug plan**²

CATEGORY C (Dental Plans)—Please select one

- Aetna Preferred Provider Organization (PPO)
- Aetna Dental Maintenance Organization (DMO)
(Benefit plan participant must reside in a DMO service area.)
- I **decline** dental coverage
- No change to **dental plan**²

CATEGORY D (Vision Plan)—Please select one

- National Vision Administrators (NVA)
- I **decline** vision coverage
- No change to **vision plan**²

¹When a retiree or dependent becomes Medicare-eligible, your health plan will coordinate with Medicare. At that time, plan changes will be required.

²If you are a new retiree, you may not select "No Change to Plan."

SIGNATURE REQUIRED

_____/_____/_____ (continue on reverse side)
Signature Date

SECTION V: COVERED PARTICIPANTS—To enroll or drop dependent(s).

First Name	Last Name	MI	Social Security #	Date of Birth	Sex	Enroll/ Drop
Spouse						<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"/>

***Please Note:** To enroll or re-enroll a QSSDP you must provide the Employee and Retiree Service Center with certification, verifying you and your dependent's continuous coverage during the previous twelve months prior to enrollment or re-enrollment. Please refer to the Retiree Benefit Summary on the ERSC website for further explanation of benefit qualifications. The completed QSSDP affidavit should include required supporting documentation. If coverage is cancelled, you may be eligible to re-enroll in the future.

FOR ADDITIONAL COVERED DEPENDENTS, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

SECTION VI: BASIC TERM LIFE INSURANCE

- Continue at retirement
- I **cancel/decline** Basic Term Life Insurance (You may not re-enroll once life insurance is cancelled.)
- No change

SECTION VII: LIFE INSURANCE BENEFICIARY DESIGNATION

- 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.

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

Primary

Name _____ Social Security # _____-____-_____

Address _____

Share _____ % Relationship _____

Primary **Contingent**

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, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

This form must be signed for selections and designations to be valid.

SIGNATURE REQUIRED _____ /_____/_____
Signature Date

Printed name _____ Employee ID # 0 0 0 0 _____