



# 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 2017  
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**INSTRUCTIONS:** All new retirees must make a selection in each category. Complete, sign electronically or manually on both sides of this form, and return to the Employee and Retiree Service Center (ERSC). You may fax the signed form to 301-279-3651 or 301-279-3642, or e-mail a PDF of the signed form to [ERSC@mcpsmd.org](mailto:ERSC@mcpsmd.org). This form must be signed at the bottom of pages 1 and 2. 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, Change in Personal Information](#) with your benefit enrollment form. Benefit enrollment confirmations are sent to the address on file.

Name \_\_\_\_\_ Employee ID # \_\_\_\_\_ 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 MCPS plan (must include MCPS Form 455-20: *Employee Benefit Plan Enrollment*)
- Reenrollment/Qualifying Event (if coverage was canceled after 7-1-98)
- Change from POS to Medicare
- Drop dependent(s)
- Deceased dependent—date of death \_\_\_\_/\_\_\_\_/\_\_\_\_
- Change of Beneficiary only—skip to **SECTION VII, LIFE INSURANCE BENEFICIARY DESIGNATION**
- I **cancel/decline** all benefit plan enrollment effective \_\_\_\_/\_\_\_\_/\_\_\_\_ (*Date of cancellation must adhere to deadline rules in RBS*)—skip to **SECTION VI, LIFE INSURANCE OPTION**

### SECTION III: RETIREE LEVEL OF HEALTH COVERAGE

- Individual
- Two-Party
- Family

### SECTION IV: TOBACCO ATTESTATION

MCPS requires that you answer the following question **ONLY** if—

- you and your spouse are covered by an MCPS-provided medical plan, **AND**
- one or both of you are **NOT** eligible for Medicare.

**Question:** Answer **ONLY** for those who are **NOT** Medicare-eligible.  
 Will you and your spouse be tobacco free throughout 2017?  Yes  No

**SECTION V: 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. **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/CareFirst Exclusive Provider Option (EPO) (an HMO option for retirees living outside the CareFirst service area)
- Kaiser Permanente HMO

#### OPEN POINT-OF-SERVICE (POS) PLANS<sup>1</sup>

- CareFirst BlueChoice Advantage

#### INDEMNITY/MEDICARE SUPPLEMENTAL PLANS

- CareFirst BlueChoice Advantage Indemnity/Medicare Supplemental Plan
- I **decline** medical coverage
- No change to **medical plan**<sup>2</sup>

#### CATEGORY B (Prescription Drug Plans)—Please select one

- Caremark (available to all non-Medicare-eligible retirees **except** Kaiser HMO members)
  - Option A  Option B
- SilverScript/Caremark Part D plan for Medicare-eligible participants (available to ages 65 + only)  Option A  Option B
- Kaiser (**only** available to Kaiser HMO members)
- I **decline** prescription drug coverage
- No change to **prescription drug plan**<sup>2</sup>

#### CATEGORY C (Dental Plans)—Please select one

- CareFirst 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**<sup>2</sup>

#### CATEGORY D (Vision Plan)—Please select one

- Davis Vision (provided through CareFirst)
- I **decline** vision coverage
- No change to **vision plan**<sup>2</sup>

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

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

**SIGNATURE REQUIRED** I understand that my electronic submission of this form, and my electronic signature, are intended to be, constitute, and are equivalent to my personal signature.  
on pages 1 and 2 \_\_\_\_\_ /\_\_\_\_/\_\_\_\_ (continue on reverse side)  
Signature Date

