Employee Benefit Plan Enrollment

for Employees With a Qualifying Life Event Only

Employee and Retiree Service Center (ERSC) • Rockville, Maryland
MONTGOMERY COUNTY PUBLIC SCHOOLS

MCPS Form 455-20
November 2017

INSTRUCTIONS: 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. 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 will become your responsibility to resubmit to ERSC by the appropriate deadline. Please see the *Employee Benefit Summary* (EBS) for deadline information.

SECTION I: EMPLOYEE INFORMATION—Please print.

Name _____ Employee ID # _____

Last Four Digits of SSN # ____ ____ ____ ____ 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. ☐ **Individual** ☐ **Two-Party** ☐ **Family**

A. Form Submission Reason

☐ Qualifying Event
Please include applicable documentation.

☐ Cancel coverage while on leave effective ____/____/_____
(Date of cancellation *must adhere to deadline rules in EBS.)*

☐ Employees Returning from Leave (must reenroll in same plan prior to leave within 60 days of return)

C. Drop Dependents

☐ Child* effective ____/____/_____

☐ Spouse* effective ____/____/_____

D. Enroll Dependent(s) **Date**

☐ Marriage* ____/____/_____
☐ Birth of Child* ____/____/_____
☐ Adoption of Child* ____/____/_____
☐ Stepchild*,** ____/____/_____
☐ Other Explain: _____

*You must attach legal documentation (i.e., birth or marriage certificate, social security number, if applicable).

** For additional requirements, please review the *Employee Benefit Summary*.

B. Action

☐ I ***decline/cancel*** all benefit plan enrollment effective ____/____/_____
—skip to **Section V, Employee Life Insurance**

☐ Change of Beneficiary only—skip to **Section VI, Life Insurance Beneficiary Designation**

☐ Add/Drop Dependent (complete Sections IIC, IID, and IV)

E. Tobacco Attestation

Have you and your spouse (if married) been tobacco free for 12 months as of the date you sign this form? ☐ Yes ☐ No

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

CATEGORY A (Medical Plans)— Please select one

☐ I ***decline*** medical coverage
☐ No change to medical plan

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

☐ CareFirst BlueChoice
☐ Kaiser Permanente

OPEN POINT-OF-SERVICE (POS) PLANS

☐ CareFirst BlueChoice Advantage

CATEGORY B (Prescription Drug Plans)—Please select one

☐ I ***decline*** prescription drug coverage
☐ No change to prescription drug plan
☐ Caremark (available to all employees **except** Kaiser HMO members)
☐ Kaiser (**only** available to Kaiser HMO members)

CATEGORY C (Dental Plans)—Please select one

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

CATEGORY D (Vision Plan)—Please select one

☐ I ***decline*** vision coverage
☐ No change to vision plan
☐ Davis Vision (provided through CareFirst)

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

List: ☐ All new participant(s) **OR** ☐ All added or dropped dependent(s). List additional dependents on an attached blank form. **Please include a copy of a marriage certificate (when enrolling a spouse) or birth certificate/birth registration (when enrolling a child).** Additional requirements are available in the *Employee Benefit Summary*.

First Name	Last Name	MI	Social Security # **(must be included)**	Date of Birth	Sex	Add/ Drop
Spouse						☐/☐
Child						☐/☐

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.

SIGNATURE REQUIRED on pages 1 and 2_____ Date _____

(continue on reverse side)

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

First Name	Last Name	MI	Social Security # **(must be included)**	Date of Birth	Sex	Add/ Drop
Child						☐/☐
Child						☐/☐
Child						☐/☐

SECTION V: BASIC EMPLOYEE TERM LIFE INSURANCE ENROLLMENT .

☐ **Category A—Active Employees Returning from Leave (within 60 days)**
- ☐ Basic Term Life Insurance
- ☐ I ***decline*** all Life Insurance coverage

☐ **Category B—Active Employees Going on Leave**
- ☐ Cancel all Life Insurance

☐ **Category C—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 _____

Address _____

Share _____% Relationship _____

☐ **Primary** ☐ **Contingent**

Name _____

Address _____

Share _____% Relationship _____

☐ **Primary** ☐ **Contingent**

Name _____

Address _____

Share _____% Relationship _____

FOR ADDITIONAL BENEFICIARIES OR COVERED PARTICIPANTS, PLEASE ATTACH AN ADDITIONAL BLANK FORM.

Name _____ Employee ID # _____

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.

SIGNATURE REQUIRED

_____ _____
Signature *Date*