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 2018

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. 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 2018? ☐ 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[1]

- ☐ CareFirst BlueChoice Advantage

INDEMNITY/MEDICARE SUPPLEMENTAL PLANS

- ☐ CareFirst BlueChoice Advantage 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 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[2]**

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[2]**

CATEGORY D (Vision Plan)—Please select one

- ☐ Davis Vision (provided through CareFirst)
- ☐ I ***decline*** vision coverage
- ☐ No change to **vision plan[2]**

[1]When a retiree or dependent becomes Medicare-eligible, your health plan will coordinate with Medicare. At that time, plan changes will be required.
[2]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 _____ *Signature* ____/____/____ *Date* (continue on reverse side)

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

First Name	Last Name	MI	Social Security #	Date of Birth	Sex	Enroll/ Drop
Spouse						☐/☐
Child						☐/☐
Child						☐/☐

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

SECTION VII: BASIC TERM LIFE INSURANCE

☐ Continue at retirement
☐ I **cancel/decline** Basic Term Life Insurance (You may not reenroll once life insurance is cancelled.)
☐ Change of beneficiary only
☐ No change

SECTION VIII: 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 _____
Address _____
Share _____ % Relationship _____

☐ **Primary** ☐ **Contingent**
Name _____
Address _____
Share _____ % Relationship _____

☐ **Primary** ☐ **Contingent**
Name _____
Address _____
Share _____ % Relationship _____

☐ **Primary** ☐ **Contingent**
Name _____
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. 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 *Signature* *Date*

Printed name _____ Employee ID # _____