

HOWARD COUNTY PUBLIC SCHOOLS ♦ BENEFITS CHANGE FORM

ACTIVE EMPLOYEES (Please Print)

1 TYPE OF REQUEST FOR STATUS CHANGE

The Benefits Change Form must be submitted to the Benefits Office within 30 days of status change, along with the necessary supporting documentation.

Reason for addition:	Date of event:	Add/Remove	Date of event	Reason for termination:	Date of event:
<input type="checkbox"/> Marriage	_____	<input type="checkbox"/> Employee	_____	<input type="checkbox"/> Other Insurance	_____
<input type="checkbox"/> Birth/Adoption of child	_____	<input type="checkbox"/> Spouse	_____	<input type="checkbox"/> Divorce	_____
<input type="checkbox"/> Loss of other Coverage	_____	<input type="checkbox"/> Child/children	_____	<input type="checkbox"/> Child reached age limit	_____
<input type="checkbox"/> Other (explain) _____		<input type="checkbox"/> Other	_____	<input type="checkbox"/> Child no longer student	_____
				<input type="checkbox"/> Other	

2 SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	MAIDEN/FORMER NAME (If Applicable)	HOME PHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	EMPLOYEE ID NUMBER E - _____	SOCIAL SECURITY NUMBER	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed

3 ELECTION OF BENEFITS - Refer to the Health Benefits Enrollment Information for Details.

MEDICAL PLAN OPTIONS: <i>Select a Plan</i> <input type="checkbox"/> Traditional Medical Plan* <input type="checkbox"/> Alternate Medical Plan <input type="checkbox"/> Aetna PPO <input type="checkbox"/> CareFirst BlueChoice HMO Open Access <input type="checkbox"/> Aetna Select Open Access HMO <input type="checkbox"/> Kaiser Permanente Select HMO <input type="checkbox"/> United Healthcare Choice HMO <small>* Not available to employees hired on or after July 1, 1993</small> <i>Select a Level of Coverage</i> <input type="checkbox"/> Individual <input type="checkbox"/> Parent & child (children for Aetna and Kaiser) <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Family <input type="checkbox"/> I cancel/waive medical coverage	INDEMNITY DENTAL PLAN OPTIONS: <i>Select a Plan</i> <input type="checkbox"/> NCAS Current Dental <input type="checkbox"/> NCAS Alternate Dental <input type="checkbox"/> Delta Dental PPO <i>Select a Level of Coverage</i> <input type="checkbox"/> Individual <input type="checkbox"/> Parent & child <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Family <input type="checkbox"/> I cancel/waive dental coverage	VISION PLAN <i>Select a Plan</i> <input type="checkbox"/> NCAS Vision Plan <input type="checkbox"/> VSP (Vision Service Plan) <i>Select a Level of Coverage</i> <input type="checkbox"/> Individual <input type="checkbox"/> Parent & child <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Family <input type="checkbox"/> I cancel/waive vision coverage FLEXIBLE SPENDING ACCOUNT <input type="checkbox"/> Health Care Spending Account \$ _____ <input type="checkbox"/> Dependent Care Account \$ _____ <input type="checkbox"/> I elect FSA coverage <input type="checkbox"/> I cancel/waive FSA coverage
VOLUNTARY LONG TERM DISABILITY: <input type="checkbox"/> I cancel/waive long term disability coverage		

4 COVERED EMPLOYEE AND DEPENDENT(S) INFORMATION

PLEASE LIST ONLY MEMBERS TO BE ADDED/REMOVED. If you are adding or removing coverage for a dependent, please check the appropriate box below and complete all of the information. If selecting Blue Choice HMO Open Access or Kaiser, indicate the primary care physician and ID#.

Last Name	First	M.I.	Relationship	<input type="checkbox"/> Add <input type="checkbox"/> Remove	Date of Birth	Social Security Number	Primary Care Physician Information (If applicable)	Existing Patient of
			Employee	<input type="checkbox"/> Add <input type="checkbox"/> Remove			NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N
			Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Remove			NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N
			Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove			NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N
			Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove			NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N
			Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove			NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N

DEPENDENT INFORMATION

Disabled? Yes No Name _____ Date of Disability _____

****You will be required to provide a disability statement to your insurance provider(s).**

5 OTHER COVERAGE INFORMATION - COMPLETE BACK OF FORM

If you have any questions concerning the benefits and services that are provided by or excluded under the agreement, please contact the applicable plan's membership services representative before signing the application form.

I hereby apply for myself and any dependents listed on this application for the coverage indicated and authorize my employer to deduct from my earnings the amount required to participate in the elected plans. I understand that the elections that I make on this form will remain in effect for the entire Plan Year, unless I am permitted to change them during the Plan Year under special rules contained in the plan that apply only in very limited situations. If I do not complete and file a new enrollment form during the next annual enrollment period, the elections I make on this form will continue in effect indefinitely until changed by me during an annual enrollment period or in connection with the special rules discussed above. I also understand that the elections I make on this form are subject to modification by the Employer to insure that the Plan complies with applicable laws or to reflect increases in the cost of the elected coverage(s) that occur during the Plan Year. I hereby consent, for myself and for all individuals covered by the Plan through me, to any investigations or inquiries into medical condition that are deemed necessary or appropriate by the Plan Administrator and to disclosures of medical records by anyone deemed necessary or appropriate by the Plan Administrator. I have carefully read this application and agree to its terms. The statements are true and complete and are representations made to induce the issuance of the subscription agreement(s) for which I have applied.

EMPLOYEE'S SIGNATURE	DATE	RETURN COMPLETED FORM TO: Howard County Public Schools, Benefits Office 10910 Route 108, Ellicott City, MD 21042	RETAIN A COPY FOR YOUR RECORDS
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5 OTHER COVERAGE INFORMATION

Are you or any member of your family covered by any other group insurance, HMO plan, or Federal program including Medicare?

Medical Yes No Dental Yes No Vision Yes No Prescription Yes No

If yes, Name of Carrier: _____ Policy ID# _____

Address: _____

Effective Date: _____

Policyholder Name: _____

Are family members covered? Yes No If yes, which ones? Employee Spouse Children

If yes, is this Plan Primary (P) or Secondary (S) for: P S Employee P S Spouse P S Children

Medicare Part A Yes No **Medicare Part B** Yes No **Medicare Part D** Yes No

If yes, Name of Carrier: _____ Health Insurance Claim# (HIC#): _____

Address: _____

Effective Date Part A: _____ Effective Date Part B: _____ Effective Date Part D: _____

Policyholder Name: _____

Are family members covered? Yes No If yes, which ones? Employee Spouse Children

If yes, is this Plan Primary (P) or Secondary (S) for: P S Employee P S Spouse P S Children