M-NCPPC BENEFITS ENROLLMENT FORM

If you are a new hire, rehire, newly eligible for benefits or have experienced a qualifying life event (marriage, divorce, newborn, etc.), it is your responsibility to complete and submit this form to the Health & Benefits Office within **45 days** of the date of your hire, becoming eligible for benefits or qualifying life event. After the **45-day** window your next opportunity to enroll will be Open Enrollment or within 45 days of a qualifying life event. *Retirees and their dependents who have reached age 65 must enroll in Medicare Part A and Medicare Part B.*

Submit completed enrollment form/documents by Fax: 301-454-1687 , email: (Benefits@mncppc.org) or mail: M-NCPPC, Health & Benefits Office, 6611 Kenilworth Avenue, Suite 404, Riverdale, MD 20737.

1. PERSONAL INFORMATION

Last Name	First Name	M.I.	Employee ID #

2. ELIGIBILITY EVENT

☐ Newly Eligible ☐ Open Enrollment ☐ Qualifying Life Event (Marriage, Newborn, Divorce, etc.) ☐ Retiree/Survivor

3. DEPENDENTS - REQUIRED: Proof of relationship (marriage certificate, birth certificate for children, etc.) and copy of Social Security Card for EACH dependent. If you have more than 4 dependents complete a second form and fill out sections 1, 3 and 4. For each Dependent note A-Add or D-Delete under each plan.

Name (Last (if different), First, Middle Initial)	Birth Date mm/dd/yyyy	Gender M/F	Relation	Social Security No. (Need Copy of Card)	Non-Medicare Medical	Medicare Medical	Dental	Vision	Prescription
EMPLOYEE/RETIREE/SURVIVOR (See Above)			SELF						
			Spouse						
			Child						
			Child						
			Child						

4. BENEFIT PLAN ELECTIONS (Go to www.mncppc.org/275 to view the Benefit Guide and supplemental information for more plan details.

MEDICAL PLAN	PRESCRIPTION DRUG PLAN	DENTAL PLAN
☐ UHC POS and/or UHC Medicare Complement ☐ UHC EPO and/or UHC EPO Medicare Eligible ☐ Kaiser HMO and/or Kaiser Medicare Complement	☐ Caremark Elect ONLY if you enroll in a UnitedHealthcare Plan.	☐ Delta Dental PPO ☐ DeltaCare USA HMO

VISION PLAN	LEGAL PLAN
EyeMed ☐ Low Level ☐ Moderate Level ☐ High Level	☐ Legal Resources

PLANS BELOW FOR ACTIVE EMPLOYEES ONLY ************

BASIC LIFE INSURANCE and AD&D	SUPPLEMENTAL LIFE INSURANCE – EOI May Be Required
☐ Two times base annual salary, maximum $200,000	☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X (maximum $750,000)

DEPENDENT LIFE (CHILD(REN)/SPOUSE)	SUPPLEMENTAL LTD	FLEXIBLE SPENDING ACCOUNT
☐ $5,000/$10,000 ☐ $10,000/$20,000 ☐ $15,000/$30,000 (EOI required for Spouse)	**(Base Annual Salary MUST exceed $108,000)**	☐ Healthcare Account $_____/year or $_____Bi-weekly ☐ Dependent Care Account $_____/year or $_____Bi-weekly

LIFE INSURANCE PLAN BENEFICIARY DESIGNATION - Applies to both Basic and Supplemental Life Insurance Plans.

Primary Beneficiary(ies)

Name (Last, Firs, MI)	Relationship	Social Security No.	Address if Different from Yours	Percent/$Amount

Secondary Beneficiary(ies)

Name (Last, Firs, MI)	Relationship	Social Security No.	Address if Different from Yours	Percent/$Amount

MISSIONSQUARE Defined Contributions - Go to www.mncppc.org/DocumentCenter/View/18284 (Enrollment Instructions)

☐ 457 Pre-Tax Deferral ☐ Traditional IRA Pre-Tax	☐ Roth IRA After-Tax

5. AUTHORIZATION AND SIGNATURE: My signature below indicates that I have read the eligibility requirements and provisions of the benefit plans in which I have enrolled referring to the Benefits Guide and supplemental materials at www.mncppc.org/275. I declare under penalty of perjury that all of the above information is true to the best of my knowledge. I authorize M NCPPC to take deductions from my earnings/pension to cover contributions towards the cost of the plans that I have elected for myself and my eligible dependents.

Employee Signature	Date
Phone Number	Email Address

For Office Use ONLY: HRIS: Verified: