M-NCPPC BENEFITS
ENROLLMENT/CHANGE 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.

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.

Contact the Health & Benefits Office if you have any questions (Phone: 301-454-1694 /Email: Benefits@mncppc.org).

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.)

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 **C-Cancel** 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 PLANS

☐ UHC POS and/or UHC Medicare Complement
☐ UHC EPO and/or UHC EPO Medicare Eligible
☐ Kaiser HMO and/or Kaiser Medicare Complement
☐ WAIVE Medical

PRESCRIPTION DRUG PLAN

☐ Caremark (*Elect ONLY if you enroll in a UnitedHealthcare Plan)*
☐ WAIVE Prescription Drug

DENTAL PLANS

☐ Delta Dental PPO
☐ DeltaCare USA HMO
☐ WAIVE Dental

VISION PLAN

EyeMed ☐ Low Level ☐ Moderate Level ☐ High Level
☐ WAIVE Vision

LEGAL PLAN

☐ Legal Resources ☐ WAIVE Legal Resources

BASIC LIFE INSURANCE & AD&D – 2 x Base Annual Salary, up to $200,000 (Coverage Automatic unless you opt-out) ***

☐ Opt-Out (Complete Opt-Out Form at www.mncppc.org/275)
☐ Re-enroll (Complete EOI Form at www.mncppc.org/275)

SUPPLEMENTAL LIFE INSURANCE – EOI May Be Required *** (Maximum Coverage - $750,000)

☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X
☐ WAIVE Supplemental Life Insurance

DEPENDENT LIFE (CHILD(REN)/SPOUSE)

☐ $5,000/$10,000
☐ $10,000/$20,000
☐ $15,000/$30,000 (EOI required for Spouse)
☐ WAIVE Dependent Life Insurance

SUPPLEMENTAL LTD

☐ Supplemental LTD **(Base Annual Salary MUST exceed $108,000)**
☐ WAIVE Supplemental LTD

FLEXIBLE SPENDING ACCOUNT

☐ Healthcare Account $_____/year or $_____Bi-weekly
☐ WAIVE Healthcare Account
☐ Dependent Care Account $_____/year or $_____Bi-weekly
☐ WAIVE Dependent Care Account

*** **Complete Life Insurance Designation of Beneficiary Form - Go to www.mncppc.org/275**

SICK LEAVE BANK → You may enroll: (1) Within 60 Days of Initial Eligibility or (2) Open Enrollment

- Your own serious medical condition
- Serious medical condition of immediate family member
- Parental responsibilities (birth of child, adoption or foster care)

Requires up to 8 hours annual/sick leave Contribution

☐ Sick Leave Bank (Go to www.mncppc.org/275 for Procedures)
☐ WAIVE Sick Leave Bank

MISSIONSQUARE RETIREMENT PLAN CONTRIBUTIONS (457 and IRAs) – For Enrollment Materials go to www.mncppc.org/DocumentCenter/View/18284

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: