MARYLAND – NATIONAL CAPITAL PARK AND PLANNING COMMISSION APPLICATION FOR BENEFIT ENROLLMENT

Check Box ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ QUALIFYING EVENT
Check Box ☐ CAREER ☐ RETIREE/SURVIVOR ☐ CONTRACT/SEASONAL

Date of Event: _____

Send Via US Mail to:	Hand deliver to Health & Benefits Inter-Office mail to Health & Benefits EOB suite 404 Send via fax to 301-454-1687
M-NCPPC Employee Health & Benefits Office 6611 Kenilworth Ave., Suite 404 Riverdale, MD 20737	Send via email to: Benefits@mncppc.org (Documents must be a PDF or Jpeg)

HEALTH & BENEFITS ONLY	DATE	INITIALS
Received		
Entered in HRIS		
Verified By		
Coverage Effective		

1. APPLICANT INFORMATION: (IF YOU ARE AGE 65 OR OLDER AND YOU ARE RETIRED OR RETIRING, YOU MUST ENROLL IN MEDICARE PART A AND B)

EMPLOYEE'S NAME (LAST) (FIRST) (MI)	HIRE DATE	EMPLOYEE NUMBER	SEX ☐ MALE ☐ FEMALE	Email Address:
MAILING ADDRESS CITY		STATE	ZIP CODE	TELEPHONE NUMBER HOME ( ) WORK ( )

2. ENROLLMENT INFORMATION 3. COVERAGE SELECTION

LIST YOUR SPOUSE AND ALL ELIGIBLE DEPENDENTS

NAME (INCLUDE LAST NAME IF DIFFERENT FROM APPLICANT) OTHERWISE LIST: FIRST NAME AND MIDDLE INITIAL	SOCIAL SECURITY NUMBER (Need copy of card)	BIRTH DATE MM. DD CCYY	CHECK ONLY IF ADDING OR DELETING	DISABLED DEPENDENT	MEDICARE ELIGIBLE	UHC EPO	UHC POS	UHC Complement	Kaiser HMO	Prescription	Dental PPO	Dental HMO	Vision High	Vision Moderate	Vision Low	Legal Resources	US Legal
EMPLOYEE/RETIREE/SURVIVOR (see above)	- -	/ /	☐ADD ☐DEL		☐Y ☐N												
SPOUSE	- -	/ /	☐ADD ☐DEL	☐Y ☐N	☐Y ☐N												
☐SON ☐DAU	- -	/ /	☐ADD ☐DEL	☐Y ☐N	☐Y ☐N												
☐SON ☐DAU	- -	/ /	☐ADD ☐DEL	☐Y ☐N	☐Y ☐N												
☐SON ☐DAU	- -	/ /	☐ADD ☐DEL	☐Y ☐N	☐Y ☐N												
☐SON ☐DAU	- -	/ /	☐ADD ☐DEL	☐Y ☐N	☐Y ☐N												
INDICATE YOUR ENROLLMENT IN EACH PLAN: S= Single T=Two Member F=Family																	

4. DESCRIBE CHANGES REQUESTED: _____ 5. REASON FOR CHANGE: _____

6. By signing this application, I am indicating that I have read and understand the back of the form. I verify that the information given is true and correct. I understand that I cannot make changes during the plan year unless I have a qualifying life event and I provide a change form along with required documentation within 45 calendar days of the event to the Health & Benefits Office. My signature authorizes the Commission to make payroll deductions or ERS to make deductions from my ERS retirement annuity, for my portion of the benefit premiums. Except for the Kaiser HMO Plan, in order to have prescription coverage, I must make a separate election from my medical plan election. If I or my dependents are enrolled in error, the Health & Benefits Office will correct the error once it is discovered. It is the responsibility of the employee, retiree or survivor to read the Employee Benefits Handbook and Enrollment Guide. I understand that my coverage and benefits may be adversely affected by my failure to provide complete, accurate and timely information.

Employee Signature _____ **Date:** _____

Maryland - National Capital Park & Planning Commission

APPLICATION FOR ENROLLMENT
INSTRUCTION SHEET

General Information

The information below shows the sections of the form that **must** be completed and describes the type of information needed to process your application for enrollment.	The Employee Health & Benefits Office will complete all shaded sections.

1. APPLICANT INFORMATION

Complete all sections. If not applicable, put N/A. Clearly print your name, employee ID number, and date of hire. Check the appropriate box for sex, marital status, and employment status. Complete your current mailing address and your telephone numbers. Forms with missing information cannot be processed by the plans.

2. ENROLLMENT INFORMATION

Print your social security number and date of birth on the EMPLOYEE line. Print the name and relationship to you of all your dependents who are eligible for health care coverage and who are to be enrolled under your plan(s). Include his or her Social Security Number (SSN) and full date of birth, including year (e.g., 04-21-1958). If you are adding or deleting a dependent, check the ADD or DEL (lete) box. **If you are adding a dependent, please include birth certificate and/ or marriage certificate and a copy of the social security card. Birth certificates must show name(s) of parents. In order to meet the 45-day deadline for newborns, hospital discharge papers can be used until the official birth certificate is received.** You will have 3 months from date of birth to provide the birth certificate and SSN. Forms with missing information cannot be processed by the plans.

Indicate by checking 'YES' or 'NO' if a dependent is disabled. If you check 'YES', further information will be sent to you.

3. COVERAGE SELECTION

Check all coverages you want for you and each dependent. For each dependent to be covered by this contract, check (✓) the coverage(s) available on the line across from his or her name in section 2. Dependents are not eligible for coverage if the employee is not enrolled in that plan. Total number of persons enrolled (the total number of checks (✓) and indicate in the blocks at the bottom: S for Single, T for Two Member or F for Family for each plan. 3. If you are making any changes, please check all plans you want for you and each dependent. You cannot enroll a dependent unless you are in the plan.

I understand that my enrollment in either of the two Legal Services plan is for a minimum of 12 months. I agree that if I cancel my enrollment within 12 months from the effective date of coverage, I am responsible for payment for the initial 12-month period.

4. DESCRIBE CHANGES REQUESTED

List the benefit plans or dependents that you are canceling or changing.

5. REASON FOR CHANGE

Please indicate the reason for change, unless the change is for open enrollment.

6. SIGNING OF APPLICATION

Read this section carefully; you must sign and date the agreement for your application to be processed. The Commission will not accept your application if this section is not completed. Processing this form may be delayed if not filled out completely. Your initial enrollment or requested changes will not be processed until all supporting documentation has been received and satisfactorily supports your request for a change in benefits.