M-NCPPC RETIREE/SURVIVOR BENEFITS
ENROLLMENT FORM

IMPORTANT: If you or your dependent are/when you reach age 65 or become eligible for Medicare for any reason, you must:

- **Enroll in Medicare Part A and Medicare Part B**
- **Provide a copy of your Medicare card to the Health & Benefits Office upon receipt**

1. PERSONAL INFORMATION			
Last Name	First Name	M.I.	Retiree/Survivor ID #

2. ELIGIBILTY EVENT

☐ RETIREE ☐ SURVIVOR

3. DEPENDENTS – REQUIRED (If applicable and not on file): 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 if not on file)	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	

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 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:

Submit your completed enrollment form to the Health & Benefits Office by:

- **Fax: 301-454-1687**
- **Email: Benefits@mncppc.org**
- **Mail: M-NCPPC, Health & Benefits Office, 6611 Kenilworth Avenue, Suite 404, Riverdale, MD 20737**