# M-NCPPC RETIREE/SURVIVOR BENEFITS ENROLLMENT/CHANGE FORM

**IMPORTANT :**

* If you drop a healthcare plan (or a dependent ), you may not re-enroll in that plan (re-enroll your dependent) without proof of your (your dependent's) continuous comparable coverage in another healthcare plan during the period in which you (your dependent) were not covered under a M-NCPPC sponsored healthcare plan.

* If you or your dependent are/reach age 65 or become eligible for Medicare for any reason, you must:
  - Enroll in Medicare Part A (Hospital) and Medicare Part B (Medical Insurance)
  - Provide the Health & Benefits Office with a copy of your Medicare ID card

Medicare becomes the primary payor and the Medicare Complement plan becomes secondary payor. The Medicare Complement Plan plan will pay after Medicare pays.

## 1. PERSONAL INFORMATION

| Last Name | First Name | M.I. | Retiree/Survivor ID # |
|---|---|---|---|
| | | | |

## 2. ELIGIBILITY 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<br>☐ UHC EPO and/or UHC EPO Medicare Eligible<br>☐ Kaiser HMO and/or Kaiser Medicare Complement | ☐ Caremark<br>Elect ONLY if you enroll in a UnitedHealthcare Plan. | ☐ Delta Dental PPO<br>☐ DeltaCare USA HMO |

| VISION PLAN | LEGAL PLAN |
|---|---|
| EyeMed<br>☐ 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**