BALTIMORE CITY PUBLIC SCHOOLS

**Baltimore City Public Schools**
Office of Human Capital,
Division of Benefits Management
200 East North Avenue, Room 110
Baltimore, Maryland 21202
Phone: 410-396-8885 Email:HumanCapital@bcps.k12.md.us

**2019**

**Employee Name** _____ **Employee ID or SSN** _____
Please print
**Union** _____ **Date of Hire** _____

**Section 1 — Enrollment Action Request**

O New Enrollment (New Employee) O Add Dependent O Terminate Dependent O Medicare/TEFRA Information

O Re-enrollment (If returning from lay-off or Approved Leave of Absence, please attach documentation)

**Section 2 — Benefit Selection** (Please check the benefit and level of coverage for which you are enrolling or making a change. You have 30 days from the date of a qualifying event (also called a change in family status - includes new hire, marriage, birth, adoption, or death) to change your enrollment in your current health plan. The Division of Benefits Management cannot process forms received beyond the 30 days of the qualifying event. Upon receipt of your enrollment form, it could take 30 days to process your enrollment request. For more details about the benefits available access the City Schools website http://www.baltimorecityschools.org/benefits.

**Health Plan** ❑ **CareFirst PPN** ❑ **CareFirst Blue Choice (POS)** ❑ **Kaiser Permanente** ❑ **Waive**

Choose a level: ❑ Individual ❑ Parent/Child ❑ Employee/Spouse ❑ Family

**Dental Plan** ❑ **CareFirst PPO Dental** ❑ **The Dental Network (company paid plan)** ❑ **Waive**

Choose a level: ❑ Individual ❑ Parent/Child ❑ Employee/Spouse ❑ Family

**Prescription Drug Plan** ❑ **Enroll** ❑ **Waive**

Choose a level: ❑ Individual ❑ Parent/Child ❑ Employee/Spouse ❑ Family

**Vision Plan (company paid plan)** ❑ **Enroll** **Vision Buy Up Plan** ❑ **Enroll** ❑ **Waive**

Choose a level: ❑ Individual ❑ Parent/Child ❑ Employee/Spouse ❑ Family

**Dependent Care Flexible Spending Account** ❑ **Enroll** ❑ **Waive**
I elect to have $_____deducted from my check (pre-tax) for this **calendar year (through 12/31).** The HRMS System will calculate the remaining pays in the year and divide the annual amount you have listed above into equal bi-weekly deductions.

**Medical Flexible Spending Account** ❑ **Enroll** ❑ **Waive**
I elect to have $_____ deducted from my check (pre-tax) for this **calendar year (through 12/31)**. The HRMS System will calculate the remaining pays in the year and divide the annual amount you have listed above into equal bi-weekly deductions.

**Optional Life Insurance** ❑ **Enroll** ❑ **Waive**
You may elect only one of the following:
❑ 1 X Salary ❑ 2X Salary ❑ 3X Salary ❑ 4X Salary ❑ 5X Salary
❑ 1 X Salary & AD&D ❑ 2X Salary & AD&D ❑ 3X Salary & AD&D ❑ 4X Salary & AD&D ❑ 5X Salary & AD&D

**Voluntary Dependent Life Insurance $10, 000** ❑ **Enroll** ❑ **Waive**

**Voluntary Spousal Life Insurance** ❑ **Enroll** **I elect to have $_____** ❑ **Waive**
**$10,000 to $100,000. Increments of $10,000. Above $30,000 requires Evidence of Insurability Form**

**Long Term Disability Benefit** ❑ **Enroll** ❑ **Waive**
You may elect only one of the following: ❑ (LTD) Plan A – 180 day waiting period ❑ (LTD) Plan B - 90 day waiting period

Please review all the sections of this form and complete them according to these instructions. An incomplete form WILL BE RETURNED and may result in a delay in processing your request.

**Section 1-Enrollment Action Request**-Select the appropriate type of action you desire.

**Section 2-Benefit Selection**

1. Select the appropriate block for the benefits in which you are enrolling or making a change. Also select level of coverage for each benefit.

**Section 3-Subscriber Information Section**

1. Fill in your name, Address, and Social Security number and pertinent information.

**Section 5-Subscriber Medicare Information**

1. If you (employee/retiree) do not have Medicare insurance, check the "No" block.
2. If you (employee/retiree) have Medicare insurance, check the "Yes" block.
3. If yes, indicate your Medicare claim number that appears on your Medicare card.
4. Indicate your effective date of your hospital insurance (Part A)
5. Indicate your effective date of Medical Insurance (Part B)

**Section 6- Other Health Insurance Information**

1. If you and any of your dependents do not have health insurance check the "No" block.
2. If you and any of your dependents have other health insurance check the "Yes" block
3. If you check "Yes", indicate the name of your spouse's or employer, names of person(s) covered, name of insurance company, the membership number, and city and state of plan.

**Section 7-General Dependent Information**

1. Please refer to the section below for eligible dependents or access the Division of Benefits Management web page for Dependent Eligibility guidelines. If you wish to add a dependent to your health plan.
   • Write the last name ONLY if different than yours, the full first name and the middle initial of each eligible dependent. • Write the relationship of each dependent to subscriber. • Write M or F to indicate the sex of the dependent. • Write the date of birth of each dependent.
   • Write the Social Security number of each dependent. • Check each benefit you wish to enroll you and your dependents.
   Sign and date the sole support statement in this selection if you provide support for a child who has a different last name. Attach the supporting documentation to this form. If you have more than 10 dependents, complete section 9 and attach a second form (available form your agency personnel/agency payroll officer).

**Dependent Eligibility –** The following are defined as eligible dependents spouse, children by natural birth, legal adoption, and designation as legal guardian or economic sole support as determined by the City Schools. The employee is required to furnish legal proof of dependent eligibility. In the case of adoption or designated guardianship court documents must be provided. In case of natural birth, a birth certificate is required. In the case of economic sole support, verification is required by the City Schools. In case or marriage, a marriage certificate is required. PROOF OF DEPENDENT ELIGIBILTY MUST BE ATTACHED.

**INCLUDE ALL DEPENDENTS YOU WISH TO HAVE COVERED ON YOUR HEALTH PLAN. ANY DEPENDENTS NOT LISTED ON THE FORM WILL NOT BE COVERED ON YOUR HEALTH PLAN.**

**Section 8- Termination of Dependents**

1. Indicate your dependent(s) name, the date of termination, reason code, and attach supporting documentation.

**Section 9-Detailed Dependent Information**

1. MEDICARE INFORMATION
   a. If your dependents do not have Medicare insurance check the "No" block.
   b. If your dependents do have Medicare insurance check the "Yes" block.
   c. If yes, indicate your dependents Medicare claim number that appears on his/her Medicare card.
   d. Indicate the effective date of Hospital Insurance (Part A).
   e. Indicate the effective date of Medical Insurance (Part B).

2. DISABLED DEPENDENT INFORMATION
   a. Indicate the name of your disabled dependent(s) who is incapable of self-support because of mental retardation or physical incapacity.
   b. Indicate date he/she became disabled.
   c. Complete a Disability Qualification Questionnaire. Contact The Division of Benefits Management to obtain the questionnaire form.

You MUST sign and date this form to obtain health insurance benefits. It will be returned to you if signature and date are omitted.

**Section 3 — Subscriber Information**

| Social Security Number | Last Name | First Name | Middle Name |
|---|---|---|---|
| | | | |

| Street Address | Apt. No. |
|---|---|
| | |

| City | State | ZIP |
|---|---|---|
| | | |

| Telephone Number ( ) | Alternate Number ( ) | Sex ❑Female ❑Male |
|---|---|---|
| | | |

| Date of Birth / / | Marital Status ❑ Single ❑ Married | Marriage Date / / |
|---|---|---|
| | | |

| Widow(er) Date / / | | |
|---|---|---|
| | | |

**Section 4 — Subscriber Medicare Information** (If actively employed, refer to "TEFRA" in your Benefit Comparison Booklet.)

Are you eligible for Medicare ❑ No Medicare ❑ Yes

Hospital Insurance (Part A) _____ Medical Insurance (Part B) _____

Effective Date _____ Effective Date _____

**Section 5 — Other Health Insurance Information** (WE REQUIRE THE INFORMATION REQUESTED IN THIS SECTION.)

Do you or your dependents have any other health insurance policy other than through City Schools? ❑ Yes ❑ No

If yes, name of person(s) covered _____

Membership Number _____

Name of Spouse's Employer _____

**Section 6 — General Dependent Information**

Please refer to the Dependent Eligibility section for the health plan you have selected. IF YOU ARE TERMINATING A DEPENDENT YOU MUST COMPLETE SECTION 7 ON THIS FORM. Check the benefit you wish to enroll you and your dependents.
TRANSACTION TYPE: A=Addition N=No Change (List all dependents currently listed on your policy)

❑ Individual ❑ Parent/Child ❑ Employee/Spouse ❑ Family*

| Trans. Type | Last Name | First Name | MI | Relationship (Specify Self) | Sex | Date of Birth | Social Security Number |
|---|---|---|---|---|---|---|---|
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I do hereby certify that I am sole support for the dependents with different last names. I have attached supporting documentation.

**Section 7 — Termination of Dependents**

Name _____ Name _____

Date of Reason / / Date of Rea

Reason Code
❑ Divorce ❑ Death ❑ Over Age Limit ❑ Other

Reason Code
❑ Divorce ❑ Death ❑ Over Age Limit ❑ Other

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**Section 8 — Detailed Dependent Information**

1. Are any of your dependents covered by Medicare? O Yes O No Name _____ Medicare Number _____

Hospital Insurance (Part A) Effective Date ___ / _____ / _____ Medicare Part B Effective Date: _____/____/_____/

2. Are any of your dependents between 19 and 26 years old? O Yes O No
If yes, do they reside at your residence or do you provide at least 50% of their financial support? O Yes O No

3. Are any of your dependents handicapped? O Yes O No Name _____

Date Disability Occurred ____ / _____ / _____

If yes, contact Division of Benefits Management for Disability Qualification Questionnaire.

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**READ CAREFULLY: THIS IS A LEGALLY BINDING AGREEMENT:**

I hereby apply for myself and any dependents listed in this form for the coverage indicated. If this form is accepted, I understand that it is subject to waiting periods, exclusions and all other provisions contained in the subscription agreement(s). I agree to pay the current and future charges for these agreement(s) so long as I remain in my present employment/retirement and authorize Baltimore City Public School (City Schools), when applicable, to deduct such charges from my pay and send them to the carrier when due.

I agree to be invoiced for the bi-weekly premiums if I should fall out of pay status. I understand it is my responsibility to pay the bi-weekly premiums in order to retain health insurance. I understand that if I do not receive my regular pay check, that I may be responsible for the bi-weekly total health insurance premiums in order to retain my benefits.

I further agree that any physician, hospital, or other provider of service is authorized to give City Schools full information, send records or copies relating to any diagnosis, treatment, care rendered to me or my eligible dependents listed on this form when benefits are applied for under the above mentioned subscription agreement(s). Such information is to be held confidential.

I have carefully read this form and agree to its terms. The statements are true and are representations made to induce the issuance of, and form part of the consideration for the subscriptions(s) for which I have applied.

Employee's Signature _____ Date _____

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