



# 2016 Health and Life Insurance PARTICIPATING AGENCIES – Election Form

# OPEN ENROLLMENT

Do not complete this form unless you are making changes.

## PRIMARY INFORMATION – Please PRINT

You may use this form to make changes for 2016. **Additional paperwork may be required** (see the Open Enrollment Guide). The deadline for changes and to submit any required paperwork is **October 16, 2015** at 5:00 p.m. ET.

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

Telephone Home #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Your email address will not be shared and will **only be used by OHR** to contact you regarding your health insurance.

### Medical (choose one)

- No Medical coverage
- Kaiser HMO (includes Kaiser Rx)
- United HealthCare HMO
- CareFirst POS High Option
- CareFirst POS Standard Option

**For eligible participants living outside the POS service area**

- CareFirst POS High Option Out-of-Area
- CareFirst POS Standard Option Out-of-Area

### Dental (choose one)

- No Dental coverage (2-year waiting period to re-enroll)
- Dental PPO (traditional dental plan)
- Dental DHMO

### Vision Plan (choose one)

- No Vision Coverage (2-year waiting period to re-enroll)
- Vision Plan

### Prescription / Rx (choose one)

*For the Kaiser medical plan, no Rx election is needed.*

- No Prescription coverage
- High Option Rx plan
- Standard Option Rx plan

### Optional Life (choose one)

*To increase coverage, a Statement of Health may be required.*

- No Optional Life coverage
- 1x annual earnings
- 2x annual earnings
- 3x annual earnings
- 4x annual earnings
- 5x annual earnings
- 6x annual earnings
- 7x annual earnings
- 8x annual earnings

### Dependent Life (choose one)

- No Dependent Life coverage
- \$2,000 / \$1,000
- \$4,000 / \$2,000
- \$10,000 / \$5,000

Over

## DEPENDENT COVERAGE – Please PRINT

To change dependent coverage, complete the section below and **include copies of the required documentation** (e.g., birth certificate, adoption certificate, marriage certificate, etc.), as noted in the Open Enrollment Guide. Note that you must elect the same coverage for yourself in the medical, prescription, dental and/or vision sections of this form (e.g., your dependent may not have the vision plan unless you do).

Add Eligible Dependent(s)

Keep Same Dependent Coverage

SOCIAL SECURITY NUMBER <i>(Required)</i>	FULL NAME OF ELIGIBLE DEPENDENT	DATE OF BIRTH	GENDER	RELATIONSHIP <i>(See Open Enrollment Guide)</i>	INSURANCE ELECTIONS
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision

Delete / Disenroll Dependent(s)

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED
	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision

## SIGNATURE (must be signed to be effective)

I have read the materials available for the County's Group Insurance Program (Program). If my employer utilizes the County's payroll system, I authorize the County to make a payroll deduction for my benefit elections and understand that the County may adjust my elections. If I pay directly for benefits insurance, I will promptly pay the cost or benefits will terminate. I understand that I can only change my elections during the year if I have a Status Change (see Summary Description). I authorize the release of enrollment information to entities such as benefit carriers to the extent necessary to properly administer my elections. I understand that electing benefits to which I or any other person is not entitled is considered fraud and if I misrepresent my eligibility or that of any other person, or fail to take the steps necessary to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, benefits will terminate. In addition, I must repay any claims which have been paid inappropriately, and I may face charges. I understand that the County expects to continue the Program, but it is the County's position that there is no implied contract between employees and the County to do so. I also understand that the County reserves the right at any time and for any reason to amend the Program, subject to the County's collective bargaining agreements. The County may also amend the Program, prospectively or retroactively to comply with applicable law.

⇒ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**IMPORTANT:** All documents MUST be signed and received by 5:00 p.m. ET, **Friday, October 16, 2015.**

Mail to: OHR Health Insurance Team, 101 Monroe St., 7<sup>th</sup> Floor, Rockville, MD 20850  
 or fax to: 240-777-5131 (include fax/mail cover sheet).

09/18/2015