2019 Health and Life Insurance
ACTIVE – Election Form

OPEN ENROLLMENT

Do not complete this form unless you are making changes or are (re)enrolling in a FSA program.

Primary Information (please print)

You may use this form to make changes for 2019. Additional paperwork may be required (see the Open Enrollment mailing). The deadline for changes and to submit any required paperwork is October 5, 2018 at 5 p.m. ET.

Employee SSN: _____ _____ _____

Employee 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

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

Dental (choose one)

- ☐ No Dental coverage (Late entrants subject to 12-month waiting period for basic and major services. Exceptions for loss of other coverage).
- ☐ Dental PPO (traditional dental plan)
- ☐ Dental DHMO

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

Vision (choose one)

- ☐ No Vision Coverage
- ☐ Vision Plan

Dependent Life (choose one)

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

Over ↺

Flexible Spending Accounts (FSAs)

☐ Health Care FSA $2,650 max/year

[ ] Per year

Eligible out-of-pocket health care expenses (such as copays for doctor office visits and prescription medications) for you and your qualified dependents are determined by Federal Internal Revenue Code. For details on eligible FSA expenses, check the OHR website.

☐ Child Care FSA $5,000 max/year

[ ] Per year

Eligible child care expenses include expenses for child care and adult care services from licensed day care centers. For details on eligible FSA expenses, check the OHR website. To be eligible, dependents must be your tax dependent who is under age 13, or 13 or older if physically or mentally incapable of self-care and residing in your home at least half the year.

☐ Commuter Choice Transit FSA
MCGEO: $230 max/month
Unrepresented: $260 max/month

[ ] Per month

Eligible work-related mass transit expenses, such as bus, light or regional rail, streetcar, trolley, subway or ferry; UberPOOL, Vanpool, Lyft Line. Available to MCGEO and unrepresented employees only.

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.). 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 *(Required)*	FULL NAME OF ELIGIBLE DEPENDENT	DATE OF BIRTH	GENDER	RELATIONSHIP	INSURANCE ELECTIONS
			☐ M ☐ F	☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision
			☐ M ☐ F	☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision
			☐ M ☐ F	☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision
			☐ M ☐ F	☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision
			☐ M ☐ F	☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision

☐ Delete / Disenroll Dependent(s)

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED
	☐	☐ Medical ☐ Dental ☐ Rx ☐ Vision
	☐	☐ Medical ☐ Dental ☐ Rx ☐ Vision

Signature (must be signed to be effective)

I have read the materials available for the County's Group Insurance Program (Program). I authorize the County to make a payroll deduction for my benefit elections for 2018. 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 also understand that the County may adjust my elections. 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 dismissal or 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 p.m. ET, Friday, October 5, 2018.

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