HOWARD COUNTY PUBLIC SCHOOLS ♦ 2021 BENEFITS CHANGE FORM
ACTIVE EMPLOYEES

1 TYPE OF REQUEST FOR STATUS CHANGE

The Benefits Change Form must be submitted to the Benefits Office within 30 days of status change, along with the necessary supporting documentation.

Reason for addition:	Date of event:	Add/Remove	Date of event	Reason for termination:	Date of event:
☐ Marriage		☐ Employee		☐ Other Insurance	
☐ Birth/Adoption of child		☐ Spouse		☐ Divorce	
☐ Loss of other Coverage		☐ Child/children		☐ Child reached age limit	
☐ Other (explain)		☐ Other			

2 SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	MAIDEN/FORMER NAME (If Applicable)	EMPLOYEE NUMBER

STREET ADDRESS	CITY	STATE	ZIP

SEX	DATE OF BIRTH	HOME PHONE NUMBER	WORK PHONE NUMBER	MARITAL STATUS
☐ M ☐ F				☐ Single ☐ Married ☐ Widowed

3 ELECTION OF BENEFITS - Refer to the Health Benefits Enrollment Information for Details.

MEDICAL PLAN OPTIONS:

Select a Plan

☐ Aetna PPO
☐ Aetna Select Open Access HMO
☐ CareFirst BlueChoice HMO Open Access

Select a Level of Coverage

☐ Individual
☐ Parent & Child(ren)
☐ Husband & Wife
☐ Family
☐ I cancel/waive medical coverage

INDEMNITY DENTAL PLAN OPTIONS:

Select a Plan

☐ Cigna Dental PPO
☐ Aetna DMO

Select a Level of Coverage

☐ Individual
☐ Parent & Child(ren)
☐ Husband & Wife
☐ Family
☐ I cancel/waive dental coverage

VISION PLAN

Select a Plan

☐ VSP (Vision Service Plan)

Select a Level of Coverage

☐ Individual
☐ Parent & Child(ren)
☐ Husband & Wife
☐ Family
☐ I cancel/waive vision coverage

FLEXIBLE SPENDING ACCOUNTS

☐ Health Care Spending Acct $ _____
☐ Dependent Care Acct $ _____

VOLUNTARY SHORT TERM DISABILITY:

☐ I elect Short Term Disability coverage
Please select eligibility waiting period

☐ !4 days

☐ I cancel / waive Short Term Disability Coverage

VOLUNTARY LONG TERM DISABILITY:

☐ I elect Long Term Disability coverage
Please select benefit percentage

☐ 50% ☐ 60%

☐ I cancel / waive Long Term Disability Coverage

☐ I cancel / Waive FSA Coverage

4 COVERED EMPLOYEE AND DEPENDENT(S) INFORMATION

PLEASE LIST ONLY MEMBERS TO BE ADDED/REMOVED. If you are adding or removing coverage for a dependent, please check the appropriate box below and complete all of the information. If selecting Blue Choice HMO Open Access or Kaiser, indicate the primary care physician and ID#.

Last Name First M.I.	Relationship	Sex	Date of Birth	Social Security Number	Primary Care Physician Information (If applicable)	Existing Patient of
	Employee ☐ Add ☐ Remove				NAME: ID#	☐ Y ☐ N
	Spouse ☐ Add ☐ Remove				NAME: ID#	☐ Y ☐ N
	Child ☐ Add ☐ Remove				NAME: ID#	☐ Y ☐ N

DEPENDENT INFORMATION

Disabled? ☐ Yes ☐ No Name _____ Date of Disability _____

You will be required to provide a disability statement to your insurance provider(s).

5 OTHER COVERAGE INFORMATION - COMPLETE BACK OF FORM

If you have any questions concerning the benefits and services that are provided by or excluded under the agreement, please contact the applicable plan's membership services representative before signing the application form.

I hereby apply for myself and any dependents listed on this application for the coverage indicated and authorize my employer to deduct from my earnings the amount required to participate in the elected plans. I understand that the elections that I make on this form will remain in effect for the entire Plan Year, unless I am permitted to change them during the Plan Year under special rules contained in the plan that apply only in very limited situations. If I do not complete and file a new enrollment form during the next annual enrollment period, the elections I make on this form will continue in effect indefinitely until changed by me during an annual enrollment period or in connection with the special rules discussed above. I also understand that the elections I make on this form are subject to modification by the Employer to insure that the Plan complies with applicable laws or to reflect increases in the cost of the elected coverage(s) that occur during the Plan Year. I herby consent, for myself and for all individuals covered by the Plan through me, to any investigations or inquiries into medical condition that are deemed necessary or appropriate by the Plan Administrator and to disclosures of medical records by anyone deemed necessary or appropriate by the Plan Administrator. I have carefully read this application and agree to its terms. The statements are true and complete and are representations made to induce the issuance of the subscription agreement(s) for which I have applied.

EMPLOYEE'S SIGNATURE _____ DATE _____

RETURN COMPLETED FORM TO:
Howard County Public Schools, Benefits Office
10910 Clarksville Pike, MD 21042

RETAIN A COPY FOR YOUR RECORDS

OTHER COVERAGE INFORMATION

Are you covered by Medicare? ☐ Yes ☐ No

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D

If yes, Medicare Policy Number: _____

Effective Date: _____

Are family members covered by Medicare? ☐ Yes ☐ No If yes, which ones? ☐ Spouse ☐ Child(ren)

Medicare Part A ☐ Yes ☐ No Medicare Part B ☐ Yes ☐ No Medicare Part D ☐ Yes ☐ No

Policyholder Name: _____

Effective Date Part A:: _____ Effective Date Part B: _____ Effective Date Part D: _____

Policyholder Name: _____

Effective Date Part A:: _____ Effective Date Part B: _____ Effective Date Part D: _____

Are family member(s) covered by any other insurance? ☐ Yes ☐ No
If yes, Which ones? ☐ Spouse ☐ Child(ren)

Policy Holder Name: _____

If yes, Name of Carrier: _____ Policy Number: _____

Coverage Effective Date: _____

Policyholder Name: _____

If yes, Name of Carrier: _____ Policy Number: _____

Coverage Effective Date: _____