



PRINCE GEORGE'S COUNTY GOVERNMENT
 BENEFITS AND PENSIONS DIVISION
 1400 MCCORMICK DRIVE, SUITE 245
 LARGO, MARYLAND 20774

FOR OFFICE USE ONLY
 Transmitted: _____
 Entered: _____

ENROLLMENT/CHANGE FORM – RETIREE/COBRA/SURVIVING SPOUSE

NAME: _____ SOCIAL SECURITY #: _____
 STREET: _____ DATE OF BIRTH: _____
 CITY/STATE: _____ ZIP: _____ EFFECTIVE DATE: _____
 PHONE: WORK: _____ HOME: _____ EMAIL: _____ GENDER: M or F

Status		Activity Requested	Reason – Change in Family Status
<input type="checkbox"/> Retired MSRS <input type="checkbox"/> Retired Police Officer <input type="checkbox"/> Retired Fire Fighter, Paramedic, ERT <input type="checkbox"/> Retired Correctional Officer <input type="checkbox"/> Retired Deputy Sheriff	<input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Dependent <input type="checkbox"/> COBRA <input type="checkbox"/> Assessor <input type="checkbox"/> Judge <input type="checkbox"/> Other	<input type="checkbox"/> Enroll Self <input type="checkbox"/> Enroll Spouse <input type="checkbox"/> Enroll Dependent(s) <input type="checkbox"/> Reinstate Coverage <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent(s) <input type="checkbox"/> Switch to New Plan <input type="checkbox"/> Other: _____	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Relocate In/Out of Area <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption or Permanent Legal Guardianship of Child Date of Event: _____

Attach documentation (i.e. Marriage License, Divorce Decree, etc.). Submit copy of Birth Certificate as soon as received.

Medical Coverage	Dental Coverage	Prescription	Vision	
<input type="checkbox"/> Individual <input type="checkbox"/> Two-Person <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	<input type="checkbox"/> Individual <input type="checkbox"/> Two-Person <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	<input type="checkbox"/> Individual <input type="checkbox"/> Two-Person <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	Base Plan <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	Buy-Up Plan <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> No Coverage

Name of Medical Plan: _____
 HMO
 PPO
 Primary Care Physician (PCP): _____

Dental DMO (Aetna Form must also be Completed for Dentist Selection).
 Dental PPO

Other Health Coverage: Must be completed if you or your dependents have other coverage.
 Name of Carrier: _____
 Policy Number: _____

DEPENDENTS	SS#	RELATION	CIRCLE COVERAGE	PRIMARY CARE PHYSICIAN	BIRTH DATE	CIRCLE ONE
1. _____	_____	Spouse	MED RX VIS DEN	_____	_____	ADD DROP
2. _____	_____	_____	MED RX VIS DEN	_____	_____	ADD DROP
3. _____	_____	_____	MED RX VIS DEN	_____	_____	ADD DROP
4. _____	_____	_____	MED RX VIS DEN	_____	_____	ADD DROP

EXPLAIN BENEFIT CHANGES (if needed): _____
 If enrolled in Kaiser Medical HMO or the Dental DMO, you and your dependents must select a Center/Dentist. If you have any questions concerning your benefits and services either provided or excluded under your choice of health plan, please contact the Member Services Department of that health plan before signing this application below.

By signing this form, I understand that I cannot make changes during the plan year unless there is a family status change and I complete a benefits form **within 30 days** of the event. Rules for the plan changes will vary depending on my status. This form authorizes any licensed physician, hospital or health care provider to furnish my health plan with such medical information about myself and any eligible dependent as needed. I understand that my coverage and benefits may be adversely affected by my failure to provide complete and accurate information.

 Signature

 Date