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

FOR OFFICE USE ONLY
Transmitted: _____
Entered: _____

ENROLLMENT/CHANGE FORM-ACTIVE EMPLOYEE

STEP 1– Please PRINT or TYPE.
Check reason for completing this form. For a Family Status Change, indicate nature of change (i.e., birth, marriage, divorce, etc.). Attach documentation (i.e., marriage certificate, divorce decree, etc.). Submit a copy of the birth certificate and social security card as soon as received.

EFFECTIVE DATE: _____

NAME: _____ **EMPLOYEE ID#:** _____ **or** **SS#: XXX-XX-** _____ **DATE OF BIRTH:** _____

STREET: _____ **CITY/STATE:** _____ **ZIP:** _____

PHONE-WORK: _____ **HOME:** _____ **DEPARTMENT** _____ **DATE OF HIRE:** _____

REASON: _____ **NEW EMPLOYEE** _____ **OPEN ENROLLMENT** _____ **STATUS CHANGE** _____
TYPE OF CHANGE **DATE OF EVENT**

STEP 2 **– Put an X by the Health Coverage in which you want to enroll. NOTE: LTGF Employees may only elect medical coverage.**

MEDICAL COVERAGE	DENTAL COVERAGE
State Name of Medical Plan: _____ HMO Center _____ _____PPO ☐ Individual ☐ Two-Person ☐ Family ☐ No Coverage	_____PPO _____DMO (Must complete provider form to select dentist) ☐ Individual ☐ Two-Person ☐ Family ☐ No Coverage
MEDICAL OPT OUT CREDIT	**PRESCRIPTION OPT OUT CREDIT**
☐ Opt Credit ($400) – Proof of Coverage Required Must Be Renewed Annually	☐ Opt Credit ($200) – Must Be Renewed Annually
VISION	**PRESCRIPTION**
☐ BASE PLAN ☐ BUY-UP PLAN ☐ Individual ☐ Family ☐ No Coverage	☐ Individual ☐ Two-Person ☐ Family ☐ No Coverage

STEP 3 — Complete this section and mark an X for each plan you elect for you and the dependents you will cover. To DROP a dependent, list name and mark the 'drop' box with an "X".

Full Name (PRINT) First / Middle Initial / Last	DROP	Relationship	Sex	Social Security No.	Birth Date	MED	RX	VIS	DEN
	☐	SPOUSE				☐	☐	☐	☐
	☐					☐	☐	☐	☐
	☐					☐	☐	☐	☐
	☐					☐	☐	☐	☐

STEP 4 - REDUCED LIFE INSURANCE - Complete this section to reduce your life insurance and receive an opt out credit or to cancel the credit.

☐ Reduce Life Insurance to 1X ☐ Cancel (Resume 2x Base Pay)	Office Use Only: Credit Amount _____

FOR STEPS 5 and 6: Unless you are a new employee, you are required to complete an Evidence of Insurability Form.

STEP 5 - EXTRA LIFE INSURANCE - Complete this section to INCREASE, CHANGE or DROP your life insurance. The Extra Life Insurance is IN ADDITION to the 2 times your annual salary of Basic life insurance provided by the County. Rates will increase based on salary and age.

☐ Additional 1X Base Pay ☐ Additional 2X Base Pay ☐ Additional 3X Base Pay ☐ Additional 4X Base Pay ☐ Drop Extra Life Insurance Coverage

STEP 6 – Long-Term Disability - Complete this section to ENROLL, CHANGE or DROP the Long-Term Disability coverage.

☐ 50% of base pay after 180 days	☐ 60% of base pay after 180 days	☐ DROP Long-Term Disability Coverage

STEP 7- FLEXIBLE SPENDING ACCOUNTS - Complete this section to ENROLL or RENEW the Flexible Spending Accounts. Employee must renew enrollment EACH plan year and indicate Annual Amount.

Health Care Flexible Spending Account Annual Amount_____	Dependent Care Flexible Spending Account Annual Amount _____

STEP 9 - Read the statement below and sign your name.

By signing this form, I understand that my premiums will be deducted on a pre-tax basis, except for Extra Life Insurance and Long-Term Disability. No changes can be made during the plan year unless there is a qualified status event and I complete a benefits enrollment form within 30 days of the event. 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**

Distribution: *White* - Office of Human Resources Management / *Yellow* - Employee