PRINCE GEORGE'S COUNTY GOVERNMENT
BENEFITS ADMINISTRATION DIVISION
1400 MCCORMICK DRIVE, SUITE 245, LARGO, MARYLAND 20774
BENEFITS@CO.PG.MD.US FAX: 301-883-6192

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
☐ Retired MSRS ☐ Retired Police Officer ☐ Retired Fire Fighter, Paramedic, ERT ☐ Retired Correctional Officer ☐ Retired DeputY Sheriff	☐ Surviving Spouse ☐ Surviving Dependent ☐ COBRA ☐ Assessor ☐ Judge ☐ Other	☐ Enroll Self ☐ Enroll Spouse ☐ Enroll Dependent(s) ☐ Reinstate Coverage ☐ Remove Spouse ☐ Remove Dependent(s) ☐ Switch to New Plan ☐ Other: _____	☐ Retirement ☐ Medicare ☐ Relocate In/Out of Area ☐ Marriage ☐ Divorce ☐ Birth of Child ☐ 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	
				Base Plan	Buy-Up Plan
☐ Individual ☐ Two-Person ☐ Family ☐ No Coverage	☐ One Senior ☐ Two Seniors ☐ Individual plus Senior	☐ Individual ☐ Two-Person ☐ Family ☐ No Coverage	☐ Individual ☐ Two-Person ☐ Family ☐ No Coverage	☐ Individual ☐ Two-Person ☐ Family ☐ No Coverage	☐ Individual ☐ Two-Person ☐ Family ☐ 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**