



PRINCE GEORGE'S COUNTY GOVERNMENT
 BENEFITS ADMINISTRATION, 1400 McCORMICK DRIVE, LARGO, MARYLAND 20774
ENROLLMENT/CHANGE FORM – RETIREE/COBRA/SURVIVING SPOUSE

FOR OFFICE USE ONLY
 Transmitted: _____
 Entered: _____

[PLEASE PRINT]

NAME _____ SS# _____
 STREET _____ DATE OF BIRTH _____
 CITY/STATE _____ ZIP _____ EFFECT. DATE _____
 PHONE-WORK _____ HOME _____ EMAIL _____ GENDER _____

Status	Activity Requested	Reason - Change in Family Status
<input type="checkbox"/> Retired MSRS <input type="checkbox"/> Retired Police Officer <input type="checkbox"/> Retired Firefighter, 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"/> One Senior <input type="checkbox"/> Two Seniors <input type="checkbox"/> Individual plus Senior	<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"/> Family <input type="checkbox"/> No Coverage

State Name of Medical Plan: _____
 HMO
 POS
 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 a Medical HMO or the Dental DMO, you and your dependents must select a primary care physician/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 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 _____