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 |
|---|---|---|---|
| ☐ Retired MSRS | ☐ Surviving Spouse | ☐ Enroll Self | ☐ Open Enrollment |
| ☐ Retired Police Officer | ☐ Surviving Dependent | ☐ Enroll Spouse | ☐ Relocate In/Out of Area |
| ☐ Retired Firefighter, Paramedic, ERT | ☐ COBRA | ☐ Enroll Dependent(s) | ☐ Marriage |
| ☐ Retired Correctional Officer | ☐ Assessor | ☐ Reinstate Coverage | ☐ Divorce |
| ☐ Retired Deputy Sheriff | ☐ Judge | ☐ Remove Spouse | ☐ Birth of Child |
| | ☐ Other | ☐ Remove Dependent(s) | ☐ Adoption or permanent legal guardianship of child |
| | | ☐ Switch to New Plan | |
| | | ☐ Other: _____ | **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 |
|---|---|---|---|
| ☐ 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 ☐ Family ☐ 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**

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