

## M-NCPPC BENEFITS ENROLLMENT FORM

If you are a new hire, rehire, newly eligible for benefits or have experienced a qualifying life event (marriage, divorce, newborn, etc.), it is your responsibility to complete and submit this form to the Health & Benefits Office within **45 days** of the date of your hire, becoming eligible for benefits or qualifying life event. After the **45-day** window your next opportunity to enroll will be Open Enrollment or within 45 days of a qualifying life event. *Retirees and their dependents who have reached age 65 must enroll in Medicare Part A and Medicare Part B.*

Submit completed enrollment form/documents by Fax: 301-454-1687 , email: ([Benefits@mncppc.org](mailto:Benefits@mncppc.org)) or mail: M-NCPPC, Health & Benefits Office, 6611 Kenilworth Avenue, Suite 404, Riverdale, MD 20737.

1. PERSONAL INFORMATION												
Last Name			First Name			M.I.		Employee ID #				
2. ELIGIBILITY EVENT												
<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Newly Eligible <input type="checkbox"/> Qualifying Life Event (Marriage, Newborn, Divorce, etc.) <input type="checkbox"/> Retiree/Survivor												
3. DEPENDENTS - REQUIRED: Proof of relationship (marriage certificate, birth certificate for children, etc.) and copy of Social Security Card for EACH dependent. If you have more than 4 dependents complete a second form and fill out sections 1, 3 and 4. For each Dependent note A-Add or D-Delete under each plan.												
Name (Last (if different), First, Middle Initial)		Birth Date mm/dd/yyyy		Gender: M/F	Relation	Social Security No. (Need Copy of Card)		Non-Medicare Medical	Medicare Medical	Dental	Vision	Prescription
EMPLOYEE/RETIREE/SURVIVOR (See Above)					SELF							
					Spouse							
					Child							
					Child							
					Child							
4. BENEFIT PLAN ELECTIONS (Go to <a href="http://www.mncppc.org/275">www.mncppc.org/275</a> to view the Benefit Guide and supplemental information for more plan details.)												
<b>MEDICAL PLAN</b>					<b>PRESCRIPTION DRUG PLAN</b>			<b>DENTAL PLAN</b>				
<input type="checkbox"/> UHC POS and/or UHC Medicare Complement <input type="checkbox"/> UHC EPO and/or UHC EPO Medicare Eligible <input type="checkbox"/> Kaiser HMO and/or Kaiser Medicare Complement					<input type="checkbox"/> Caremark  Elect ONLY if you enroll in a UnitedHealthcare Plan.			<input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> DeltaCare USA HMO				
<b>VISION PLAN</b>					<b>LEGAL PLAN</b>							
EyeMed <input type="checkbox"/> Low Level <input type="checkbox"/> Moderate Level <input type="checkbox"/> High Level					<input type="checkbox"/> Legal Resources							
PLANS BELOW FOR ACTIVE EMPLOYEES ONLY *****					PLANS BELOW FOR ACTIVE EMPLOYEES ONLY *****							
<b>BASIC LIFE INSURANCE and AD&amp;D</b>					<b>SUPPLEMENTAL LIFE INSURANCE – EOI May Be Required</b>							
<input type="checkbox"/> Two times base annual salary, maximum \$200,000					<input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> 5X    (maximum \$750,000)							
<b>DEPENDENT LIFE (CHILD(REN)/SPOUSE)</b>			<b>SUPPLEMENTAL LTD</b>		<b>FLEXIBLE SPENDING ACCOUNT</b>							
<input type="checkbox"/> \$5,000/\$10,000 <input type="checkbox"/> \$10,000/\$20,000 <input type="checkbox"/> \$15,000/\$30,000 (EOI required for Spouse)			(Base Annual Salary <b>MUST</b> exceed \$108,000)		<input type="checkbox"/> Healthcare Account \$_____/year or \$_____/Bi-weekly <input type="checkbox"/> Dependent Care Account \$_____/year or \$_____/Bi-weekly _____							
LIFE INSURANCE PLAN BENEFICIARY DESIGNATION - Applies to both Basic and Supplemental Life Insurance Plans.												
<b>Primary Beneficiary(ies)</b>												
Name (Last, Firs, MI)		Relationship		Social Security No.	Address if Different from Yours			Percent/\$Amount				
<b>Secondary Beneficiary(ies)</b>												
Name (Last, Firs, MI)		Relationship		Social Security No.	Address if Different from Yours			Percent/\$Amount				
ICMA-RC Defined Contributions - Complete Enrollment Form at <a href="http://www.mncppc.org/275">www.mncppc.org/275</a> to set up account.. Call ICMA-RC for Account questions: 800-669-7400.												
<input type="checkbox"/> 457 Pre-Tax Deferral \$_____/year or \$_____/Bi-weekly <input type="checkbox"/> Traditional IRA Pre-Tax \$_____/year or \$_____/Bi-weekly					<input type="checkbox"/> Roth IRA After-Tax \$_____/year or \$_____/Bi-weekly							
5. AUTHORIZATION AND SIGNATURE: My signature below indicates that I have read the eligibility requirements and provisions of the benefit plans in which I have enrolled referring to the Benefits Guide and supplemental materials at <a href="http://www.mncppc.org/275">www.mncppc.org/275</a> . I declare under penalty of perjury that all of the above information is true to the best of my knowledge. I authorize M-NCPPC to take deductions from my earnings/pension to cover contributions towards the cost of the plans that I have elected for myself and my eligible dependents.												
Employee Signature					Date							
Phone Number					Email Address							
For Office Use ONLY: HRIS:					Verified:							