BALTIMORE COUNTY PUBLIC SCHOOLS
FLEXIBLE BENEFITS ENROLLMENT/CHANGE APPLICATION
ACTIVE EMPLOYEES (Please print)*

RETURN COMPLETED FORM TO: **Baltimore County Public Schools, Office of Employee Benefits, Leaves and Retirement**
6901 N. Charles Street, Building B, Towson, MD 21204 • Phone: (443) 809-8943

SCAN AND E-MAIL FORM TO: benefits@bcps.org **FAX TO: (410) 887-8950**

1. TYPE OF REQUEST- This application is for one of the following:

☐ New hire (Effective _____) ☐ Change in status (Check below) (Effective _____) ☑ Open Enrollment (Effective 01/01/2021

If you have experienced a change in status outside of Open Enrollment, please select one of the following qualifying life events:

☐ Marriage
☐ Divorce
☐ Birth/Adoption of a child
☐ Death
☐ Other _____
☐ Loss of Non-BCPS coverage
☐ Gain of Non-BCPS coverage
☐ Increase or Reduction of FTE

Reminder: A change in status request must include documentation supporting the requested change. Both this form and the documentation must be received within 30 days of the qualifying event. With the exception of birth, adoption, and divorce, all other changes will be processed for the first of the month following receipt of the request.

2. SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	E-MAIL ADDRESS

STREET ADDRESS	APT. NO.	JOB TITLE

CITY	STATE	ZIP

SEX	DATE OF BIRTH	PHONE NO.	MARITAL STATUS	DATE OF MARRIAGE/DIVORCE
☐ M ☐ F			☐ Single ☐ Married ☐ Divorced	

3. ELECTION OF BENEFITS - Refer to the Benefits Enrollment and Reference Guide for Details.

MEDICAL PLAN OPTIONS:
Select a plan
☐ Cigna OAPIN (in network only)
☐ Kaiser Permanente HMO
☐ Cigna OAP (in/out network)

Choose a coverage level
☐ Individual
☐ Parent & Child
☐ Parent & Children (children for Kaiser only)
☐ Two Adults
☐ Family
☐ I cancel/waive medical coverage

VISION INSURANCE:
CareFirst Davis Plan - Employee coverage is free if your FTE is .500 or greater
☐ Individual
☐ Family
☐ I cancel/waive family vision coverage

LONG-TERM DISABILITY:
☐ I elect LTD coverage
☐ I cancel/waive LTD coverage

PERSONAL ACCIDENT INSURANCE:
☐ Employee Benefit Amount $_____,000
☐ Spouse : __50% or __100%
☐ Children: 10%
☐ I cancel/waive PAI coverage

DENTAL PLAN OPTIONS:
Select a plan
☐ CareFirst BCBS Regional Dental PPO
☐ CareFirst BCBS Regional Dental Traditional
☐ Cigna Dental Care Access DHMO

Choose a coverage level
☐ Individual
☐ Parent & Child
☐ Parent & Children (children for Cigna only)
☐ Two Adults
☐ Family
☐ I cancel/waive dental coverage

4. COVERED EMPLOYEE AND DEPENDENT(S) INFORMATION

PLEASE LIST ALL MEMBERS TO BE COVERED. If you are adding or removing coverage for a dependent, please check the appropriate box below and complete all of the information.

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	KAISER MEDICAL FACILITY/PRIMARY CARE	DHMO FACILITY #
			EMPLOYEE/ APPLICANT				NAME:	
			SPOUSE ○ADD ○REMOVE				NAME:	
			CHILD ○ADD ○REMOVE				NAME:	
			CHILD ○ADD ○REMOVE				NAME:	
			CHILD ○ADD ○REMOVE				NAME:	
			CHILD ○ADD ○REMOVE				NAME:	

If you have any questions concerning the benefits and services that are provided by or excluded under the agreement, please contact the applicable plan's membership services representative before signing the application form.
I hereby apply for myself and any dependents listed on this application for the coverage indicated and authorize my employer to deduct from my earnings the amount required to participate in the elected plans. I understand that the elections that I make on this form will remain in effect for the entire Plan Year, unless I am permitted to change them during the Plan Year under special rules contained in the plan that apply only in very limited situations. If I do not complete and file a new enrollment form during the next annual enrollment period, the elections I make on this form will continue in effect indefinitely until changed by me during an annual enrollment period or in connection with the special rules discussed above. I also understand that the elections I make on this form are subject to modification by the Employer to insure that the Plan complies with applicable laws or to reflect increases in the cost of the elected coverage(s) that occur during the Plan Year. I hereby consent, for myself and for all individuals covered by the Plan through me, to any investigations or inquiries into medical condition that are deemed necessary or appropriate by the Plan Administrator and to any disclosures of medical records by anyone deemed necessary or appropriate by the Plan Administrator. I have carefully read this application and agree to its terms. The statements are true and complete and are representations made to induce the issuance of the subscription agreement(s) for which I have applied.

_____
EMPLOYEE'S SIGNATURE DATE

RETAIN A COPY FOR YOUR RECORDS