The Maryland-National Capital Park and Planning Commission

Retiree and Survivor Benefits Enrollment and Change Form

Important

If you (or a dependent) drops a healthcare plan, you or your dependent may not re-enroll in that plan without proof of continuous comparable coverage in another healthcare plan during the period in which you and your dependent were not covered under a M-NCPPC sponsored healthcare plan.

If you or your dependent are/reach age 65 or become eligible for Medicare for any reason, you must: Enroll in Medicare Part A (Hospital) and Medicare Part B (Medical Insurance) - Provide the Health & Benefits Office with a copy of your Medicare ID card. Medicare becomes the primary payor and the Medicare Complement plan becomes secondary payor. The Medicare Complement Plan plan will pay after Medicare pays.

Submit your completed enrollment form and documents by fax to 301-454-1687, **email to Benefits@mncppc.org or mail to** M-NCPPC, Health & Benefits Office, 6611 Kenilworth Avenue, Suite 404, Riverdale, MD 20737.

For questions, contact the Health & Benefits Office at 301-454-1694 or **Benefits@mncppc.org**

Employee Information

Last Name	First Name	M.I.	Retiree or Survivor ID Number
_____	_____	_____	_____

Provide Your Eligibility Event ☐ **New Retiree** ☐ **New Survivor** ☐ **Changing Healthcare Plan Elections ***
☐ **Re-Enroll (with proof of comparable, continuous coverage)** * Reason for change _____

Medical Plans

☐ Cigna OAP and or Cigna Medicare Complement ☐ Cigna In-Network and or Cigna In-Network Medicare Eligible
☐ Kaiser HMO and or Kaiser Medicare Complement

Prescription Drug (Kaiser Members Excluded) ☐ **Caremark / SilverScript**

Dental Plan ☐ **Delta Dental PPO** ☐ **DeltaCare USA HMO**

EyeMed Vision Plans ☐ **Low** ☐ **Moderate** ☐ **High**

Legal Plan ☐ Legal Resources

Dependent Enrollment For each Dependent note A for Add or C to Cancel under each plan. REQUIRED: Proof of relationship such as 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 the following sections.

Relation	Name Last and First	Date of Birth	Male/Female	Social Security Number
_____	_____	_____	_____	_____

____ Medical ____ Dental ____ Vision ____ Prescription Plan

Relation	Name Last and First	Date of Birth	Male/Female	Social Security Number
_____	_____	_____	_____	_____

____ Medical ____ Dental ____ Vision ____ Prescription Plan

Relation	Name Last and First	Date of Birth	Male/Female	Social Security Number
_____	_____	_____	_____	_____

____ Medical ____ Dental ____ Vision ____ Prescription Plan

Relation	Name Last and First	Date of Birth	Male/Female	Social Security Number
_____	_____	_____	_____	_____

____ Medical ____ Dental ____ Vision ____ Prescription Plan

Authorization: My typed name 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 www.mncppc.org/275 .
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 Name	Date
_____	_____
Phone Number	Email Address
_____	_____