M-NCPPC BENEFITS
ENROLLMENT/CHANGE FORM

If you are a new hire/newly eligible, rehire 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.

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

Contact the Health & Benefits Office if you have any questions (Phone: 301-454-1694 /Email: Benefits@mncppc.org).

1. PERSONAL INFORMATION

Last Name	First Name	M.I.	Employee ID #

2. ELIGIBILITY EVENT

☐ NEW HIRE/NEWLY ELIGIBLE ☐ REHIRE ☐ OPEN ENROLLMENT ☐ QUALIFYING LIFE EVENT (Marriage, Divorce, Newborn, etc.)

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 **C-Cancel** 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)	Medical	Dental	Vision	Prescription
			SELF		☐	☐	☐	
			Spouse		☐	☐	☐	☐
			Child		☐	☐	☐	☐
			Child		☐	☐	☐	☐
			Child		☐	☐	☐	☐

4. BENEFIT PLAN ELECTIONS: Go to www.mncppc.org/275 for the Benefit Guide and supplemental information for more plan details OR visit the Virtual Benefit Fair (www.mncppc.vfairs.com) where you will find vendor booths with brochures ,videos and on-demand webinars.

MEDICAL PLAN	PRESCRIPTION PLAN	DENTAL PLAN	EYEMED VISION PLAN	LEGAL PLAN
☐ UHC POS ☐ UHC EPO ☐ KAISER HMO (includes Prescription) ☐ WAIVE	☐ CAREMARK ☐ WAIVE	☐ DELTA DENTAL PPO ☐ DELTACARE USA HMO ☐ WAIVE	☐ LOW ☐ MODERATE ☐ HIGH ☐ WAIVE	☐ LEGAL RESOURCES ☐ WAIVE
BASIC LIFE & AD&D (Automatic unless opt-out)	**SUPPLEMENTAL LIFE** (Maximum $750,000)	**DEPENDENT LIFE** (Child(ren)/Spouse)	**SUPPLEMENTAL LTD** (Salary MUST Exceed $108,000)	**SICK LEAVE BANK**
☐ Opt-Out (Complete Opt-Out Form at www.mncppc.org/275) ☐ Re-enroll (Complete EOI Form at www.mncppc.org/275)	☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X ☐ 6X ☐ 7X ☐ 8X ☐ WAIVE	☐ $5,000/$10,000 ☐ $10,000/$20,000 ☐ $15,000/$30,000* *Your spouse must complete EOI (Evidence of Insurability Form at www.mncppc.org/275) ☐ WAIVE	☐ Supplemental LTD ☐ WAIVE	☐ SICK LEAVE BANK ☐ WAIVE

Complete Life Insurance Designation of Beneficiary Form. Go to www.mncppc.org/275

FLEXIBLE SPENDING ACCOUNT

Healthcare Account	Dependent Care Account
☐ $_____/year or $_____Bi-weekly	☐ $_____/year or $_____Bi-weekly
☐ WAIVE	☐ WAIVE

MISSION SQUARE RETIREMENT SAVINGS (457, ROTH AND TRADITIONAL IRA)

Enroll On-line at www.missionsq.org/enroll

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 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 Signature	Date
Phone Number	Email Address

For Office Use ONLY: HRIS: Verified:

Effective Date: