The Maryland-National Capital Park and Planning Commission

Employee Benefits Enrollment and Change Form

If you are a new employee, eligible to be rehired, or have a major life event like getting married, divorced, or having a baby, you must send this form to the Health & Benefits Office within 45 days of the event. If you miss the deadline, you can sign up during Open Enrollment or within 45 days of another major life change.

For more plan details, go to **www.mncppc.org/275** for the Benefit Guide and supplemental information. Select your Medical Plan, Prescription, Dental, Vision, Legal, Supplemental Life Insurance, Dependent Life Insurance, Flexible Spending Account, and Sick Leave Bank. If you opt out of any benefits, select Waive. You may also opt out of Basic Life Insurance and A.D. & D.

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.	Employee ID Number
_____	_____	_____	_____

Provide Your Eligibility Event ☐ New Hire or New Eligible ☐ Rehire ☐ Open Enrollment

☐ Qualifying Event - Marriage, Divorce, Newborn

Medical Plans

☐ UHC POS and or UHC Medicare Complement ☐ UHC EPO and or UHC EPO Medicare Eligible

☐ Kaiser HMO and or Kaiser Medicare Complement ☐ Waive Medical

Prescription Drug Plan UHC Medical Only ☐ Caremark ☐ Waive Drug Plan

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

EyeMed Vision Plans ☐ Low ☐ Moderate ☐ High ☐ Waive Vision

Legal Plan ☐ Legal Resources ☐ Waive Legal

Sick Leave Bank Enrollment

Join within 60 days of eligibility or during Open Enrollment. Use the Sick Leave Bank for your own or an immediate family member's serious medical condition, or for parental responsibilities (birth, adoption, foster care). Requires up to 8 hours of annual sick leave contribution. ☐ Sick Leave Bank ☐ Waive Sick Leave Bank

Flexible Spending Accounts

☐ Healthcare Account $_____ /year or $ ____ Biweekly ☐ Waive Healthcare Account

☐ Dependent Care Account $_____ /year or $____ Biweekly ☐ Waive Dependent Care Account

Basic Life Insurance and A.D.& D. 2 times base salary up to $200,000 automatic coverage unless opt out.

☐ Opt-Out **Complete Opt-Out Form** ☐ Re-enroll **Complete EOI Form**

Supplemental Life Insurance - Salary Incremental with Maximum of $750,000 *EOI may be required

☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X ☐ 6X ☐ 7X ☐ 8X ☐ Waive Supplemental Life Insurance

Dependent Life Insurance for Children or Spouse ** EOI required for $30,000 Spousal Life

☐ $5,000/$10,000 ☐ $10,000/$20,000 ☐ $15,000/$30,000 ☐ Waive Dependent Life Insurance

Supplemental LTD – Base salary must exceed $108,000 ☐ Supplemental LTD ☐ Waive Supplemental LTD

Dependent Enrollment For each Dependent note **A for Add or C to Cancel** for 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** **Social Security Number**

_______ ____________________________________ ___________ _____________________

Male/Female _____ Benefits: ____Medical ____Dental ____Vision ____Prescription Plan

Relation **Name Last and First** **Date of Birth** **Social Security Number**

_______ ____________________________________ ___________ _____________________

Male/Female _____ Benefits: ____Medical ____Dental ____Vision ____Prescription Plan

Relation **Name Last and First** **Date of Birth** **Social Security Number**

_______ ____________________________________ ___________ _____________________

Male/Female _____ Benefits: ____Medical ____Dental ____Vision ____Prescription Plan

Relation **Name Last and First** **Date of Birth** **Social Security Number**

_______ ____________________________________ ___________ _____________________

Male/Female _____ Benefits: ____Medical ____Dental ____Vision ____Prescription Plan

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** ______________

Email Address ____ **Phone Number** ___________________

HRIS _______ **Verified**______