Commissioners of St. Mary's County

Retiree Benefits Enrollment/Change Form

Effective July 1, 2024

DO NOT RETURN THIS FORM IF YOU ARE NOT MAKING CHANGES

Please send your completed form to the Department of Human Resources by fax 301-475-4082, by email to ***benefits@stmarysmd.com****, by mail to St. Mary's County Government, Human Resources, PO Box 653, Leonardtown, MD 20650*

Last Name	First Name, MI	Social Security Number
Address		
City	State and Zip Code	Email Address
Phone Number	Date of Birth	Status ☐ Retiree ☐ Surviving Spouse

Medical Plan Election	
Under 65 Retirees	**Retirees 65 & Older**
☐ BlueChoice Advantage Medical Plan with Prescription Drug Coverage	☐ BlueChoice Advantage Medicare Supplement Plan with Prescription Drug Coverage
☐ HMO Open Access Medical Plan with Prescription Drug Coverage	☐ HMO Open Access Medicare Supplement Plan with Prescription Drug Coverage
☐ Cancel Medical Coverage	☐ Cancel Medical Coverage
Dental Plan Election	**Vision Plan Election**
☐ Cancel Dental Coverage	☐ Cancel Vision Coverage

COVERED SPOUSE AND DEPENDENT(S) INFORMATION

Complete this section if you are adding or removing a spouse or dependent

If you are switching to the HMO plan, you must select a primary care physician for yourself and each family member. If this information is missing, we cannot enroll you in coverage.

FIRST NAME MI LAST NAME	RELATIONSHIP	BIRTH DATE	PLAN TYPE Check one or all	GENDER M/F	SOCIAL SECURITY NUMBER	If HMO List Name Of Primary Care Physician
	Spouse ☐ Add ☐ Remove		Medical ☐ Dental ☐ Vision ☐			
	Child ☐ Add ☐ Remove		Medical ☐ Dental ☐ Vision ☐			
	Child ☐ Add ☐ Remove		Medical ☐ Dental ☐ Vision ☐			

AUTHORIZATION – I understand that my health insurance coverage elections are binding for the duration of the plan year and that I may only change my coverage elections during the plan year if I experience a qualifying life event (marriage, adoption/birth of a child, death of a dependent). I understand that should I cancel my medical coverage my prescription drug coverage will also be cancelled and that I cannot re-enroll at a later date.

Signature ______________________ Date ______________