Frederick County Public Schools Enrollment or Change Form

1. SUBSCRIBER INFORMATION

Employee ID	Name (Last) (First) (MI)

Street Address	City State Zip

Sex	Marital Status	Date of Birth	Telephone Numbers	Retiree
M F	Single Married Divorced		Home Work	Yes No

2. HEALTH CARE OPTIONS

	Individual	Employee + 1	Family	Waive
Medical Plan BlueChoice Advantage				
Dental Plans (choose one) Dental Standard Dental Buy-up				

3. ENROLLMENT INFORMATION Please complete this information for yourself and all dependents covered by your health plan(s)

	Full Name of Covered Members and Dependents	Relationship	Social Security Number	Sex M/F	Birth Date MM/DD/YY	Disabled Y/N
*E						
*S						
*C						
*C						
*C						
*C						

***E = Employee *S = Spouse *C = Child**

Supporting Documentation Attached

4. TERMINATION OF DEPENDENTS

Name	Termination Date	Reason Code

Reason Codes
1. Divorce
2. Death
3. Child reached age limit
4. Entered military
5. Other insurance

5. MEDICARE INFORMATION (to be completed if applicable)

Are you eligible for Medicare? Yes No
If yes, Medicare number________________________
Medicare Part A Effective Date:_________________
Medicare Part B Effective Date:_________________

Spouse? Yes No
If yes, Medicare number ________________________
Medicare Part A Effective Date: _________________
Medicare Part B Effective Date: _________________

Child? Yes No
If yes, Medicare number________________________
Medicare Part A Effective Date:_________________
Medicare Part B Effective Date:_________________

6. CONDITIONS OF ENROLLMENT

I hereby request coverage for myself and my eligible dependents, and authorize my employer to deduct from my earnings the amount required to participate in the elected Plans. I understand that all protected financial and health information for myself and any dependents will be gathered, shared and maintained in accordance with all applicable federal and state laws. Dependents may include my spouse and children under 26 years of age. Attainment of such age shall not terminate the coverage of a dependent child during the terms of this agreement if he or she is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is mainly dependent upon the subscriber for support and maintenance. Stepchildren and legally adopted children, who are in my care, are included.

I do hereby certify that I am sole support for the dependents with different last names. Enrolled dependents determined to be ineligible shall be terminated and charged for services rendered at the fee-for-service rate less any copayments and premiums paid for said dependents.

Date	Employee Signature

Return this form to the Department of Human Resources

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