

# BALTIMORE COUNTY GOVERNMENT BENEFITS CHANGE FORM

**Return to:**  
 BALTIMORE COUNTY INSURANCE DIVISION  
 400 WASHINGTON AVE, RM 111, TOWSON, MD 21204

**Phone#** 410-887-2568/ 1-800-274-4302  
**FAX #** 410-887-3820  
**MAIL STOP #** 2105

Type of Event		
Add Dependent(s)	Remove Dependent(s)	Change in Plans/Coverage Level
<input type="checkbox"/> Marriage*	<input type="checkbox"/> Legal Separation / Divorce*	<input type="checkbox"/> Loss of other coverage*
<input type="checkbox"/> Birth/Adoption of a Child*	<input type="checkbox"/> Death*	<input type="checkbox"/> Gain of other coverage*
<input type="checkbox"/> Other (please explain)	<input type="checkbox"/> Other (please explain)	<input type="checkbox"/> Other (please explain)

**DATE OF EVENT:** \_\_\_\_\_

**NOTE:** \*Change must be requested within 31 days of event and attach applicable documentation  
 (ex. proof of birth or adoption certificate, marriage license/certificate, divorce decree, etc.)

### Employee Personal Information

<b>Employee Name</b>	<b>Employee SSN</b>	<b>DOB</b>	
<b>Street</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Work Phone</b>	<b>Cell Phone</b>	<b>Home Phone</b>	<b>Email</b>

### Dependent(s) Being Added or Removed

Name	Relation	Social Security #	Gender	Date of Birth	PCP ID# & Name (Kaiser ONLY)	PCD ID # & Name (CIGNA ONLY)
Employee	Self				# Name	# Name
					# Name	# Name
					# Name	# Name
					# Name	# Name
					# Name	# Name

\*Address for Person being removed: \_\_\_\_\_  
 \_\_\_\_\_

### Medical Plans

### Dental Plans

### Vision Plan

<input type="checkbox"/> CIGNA Open Access Plus In-Net Only (OAPIN)	<input type="checkbox"/> CareFirst BCBS Traditional Dental	<input type="checkbox"/> CareFirst Davis Vision
<input type="checkbox"/> CIGNA Open Access Plus (OAP)	<input type="checkbox"/> CareFirst BCBS Preferred PPO	<input type="checkbox"/> Waive Coverage
<input type="checkbox"/> Kaiser Permanente Select HMO	<input type="checkbox"/> CIGNA Dental Care HMO	
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage	
Cov. Level : <input type="checkbox"/> IND <input type="checkbox"/> EE/SP <input type="checkbox"/> P/C <input type="checkbox"/> FAM	Cov. Level : <input type="checkbox"/> IND <input type="checkbox"/> EE/SP <input type="checkbox"/> P/C <input type="checkbox"/> FAM	Cov. Level : <input type="checkbox"/> IND <input type="checkbox"/> EE/SP <input type="checkbox"/> P/C <input type="checkbox"/> FAM

### Flexible Spending Accounts

Health Care FSA     \$ \_\_\_\_\_ per plan year

Dependent Care FSA \$ \_\_\_\_\_ per plan year

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

### To Be Completed By Baltimore County Insurance Division

Effective Date: \_\_\_\_\_                      Completed by: \_\_\_\_\_                      Date: \_\_\_\_\_

Cobra Event? \_\_\_\_\_                      If yes, date COBRA QEN sent \_\_\_\_\_