STATE OF MARYLAND
ACTIVE & SATELLITE EMPLOYEES
HEALTH BENEFITS ENROLLMENT AND CHANGE FORM FOR JULY 2013-DECEMBER 2013

PERSONAL DATA PLEASE PRINT CLEARLY

Name: __________________________________________  __________________________________________
                         LAST                     FIRST                     MI
Address: __________________________________________
City: __________________________________________  State: __________________________  Zip Code: __________________________________________
Home Phone: __________________________  Work Phone: __________________________  Cell Phone: __________________________
Personal E-mail: __________________________________________
Work E-mail: __________________________________________
Social Security Number: __ __ / __ __ / __ __
Date of Birth: __ __ / __ __ / __ __

MM /DD/  YYYY

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR
Pay Center
Work full-time or 50% or more of the normal work:
Central Payroll
University of MD
dSatellite

Agency Code: __________ Check Dist. Code: __________
(If applicable)

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

- New Employee Entry on Duty Date: __________
- Return from leave of absence/LAW Date: __________
- Open Enrollment - Effective July 1st
- Employee ineligible (e.g., change to part-time less than 50%)
- Cancel all Coverage in all Plans/Reason: __________

Change in Family Status (See Benefits Guide for documentation requirements)
Note: Request must be made within 60 days of the date of the qualifying event.

- Add dependent because of:
  - Marriage  Date: __________
  - Birth/Adoption/Appointed Permanent Legal Guardian  Date: __________
  - Other Reason: __________

- Remove dependent because of:
  - Divorce/Limited Divorce/Legal Separation  Date: __________
  - Death  Date: __________  (Attach copy of Death Certificate)
  - Dependent no longer eligible  Date: __________
  - Other Reason: __________

Note on Retroactive Adjustments:
Employees must contact their Agency Benefits Coordinator to file a Retroactive Adjustment to backdate coverage within 60 days of the date of the Change in Status or Entry on Duty. Newborn enrollment is required to be backdated to date of birth through the Retroactive Adjustment form.

COMPLETED AND SIGNED ENROLLMENT FORMS MUST BE GIVEN TO YOUR AGENCY BENEFITS COORDINATOR

If you are enrolling dependents outside of Open Enrollment, all required dependent documentation must be attached.

Health benefits information and forms are available on the Department of Budget and Management’s website:
www.dbm.maryland.gov/benefits

EBD Use Only:
Reviewed
Processed
Audited
**ENROLLMENT FOR JULY 2013-DECEMBER 2013**

**DEPENDENT INFORMATION PLEASE PRINT**

Dependent means your eligible: (a) spouse (same or opposite sex), or (b) dependent child(ren) (including biological child, adopted child, stepchild, grandchild, step grandchild, legal ward). See Benefits Guide for a complete listing of eligible dependents and the dependent documentation requirements.

Please provide your dependent information below. **PLEASE PRINT. THIS FORM MUST BE FILLED OUT COMPLETELY (INCLUDING SOCIAL SECURITY NUMBER AND DATE OF BIRTH) TO ENSURE YOUR DEPENDENTS ARE ENROLLED IN THE PLANS YOU SELECT.** Please use this section for additions (A), deletions (D) or changes (C) to your existing dependent information for Open Enrollment or a qualifying event.

<table>
<thead>
<tr>
<th>A</th>
<th>D</th>
<th>C</th>
<th>LAST NAME</th>
<th>FIRST NAME, MI</th>
<th>SEX</th>
<th>DATE OF BIRTH</th>
<th>RELATIONSHIP</th>
<th>SOCIAL SECURITY NO.</th>
<th>(A) COVER THIS DEPENDENT FOR: MEDICAL</th>
<th>DRUG</th>
<th>DENTAL</th>
</tr>
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<tbody>
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</table>

**Special Notifications:**

- Tex-qualified dependent children age 26 and over must be disabled prior to reaching age 26 in order to be eligible for continued coverage.
- Some dependents are not eligible for tax-favored coverage and you may owe increased taxes if the State subsidizes dependent coverage for individuals who are not your tax dependents. Refer to the Benefits Guide for details.
ENROLLMENT FOR JULY 2013-DECEMBER 2013

Medical Benefits

CHOOSE ONE OPTION:
- New Enrollment
- Change in plan
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- Employee Only
- Employee & One Child
- Employee & Spouse
- Employee & Family

CHOOSE ONE MEDICAL PLAN:
- Aetna EPO*
- Aetna POS
- CareFirst BC/BS EPO
- CareFirst BC/BS POS*
- CareFirst BC/BS PPO
- UnitedHealthcare EPO*
- UnitedHealthcare POS
- UnitedHealthcare PPO

The plans with an asterisk (*) require a Primary Care Physician once enrolled. Call plan or see plan website for details.

If you or a dependent have Medicare, write in name, Medicare number, and effective date of Medicare coverage.

<table>
<thead>
<tr>
<th>NAMES OF INDIVIDUALS</th>
<th>MEDICARE NUMBER</th>
<th>PART A EFFECTIVE DATE</th>
<th>PART B EFFECTIVE DATE</th>
<th>PART D EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WITH MEDICARE</td>
<td>(with suffix)</td>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
</tr>
<tr>
<td>Employee</td>
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<tr>
<td>Spouse</td>
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<td>Child</td>
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<tr>
<td>Child</td>
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</tbody>
</table>

NOTE: Vision and Mental Health/Substance Abuse benefits are included if enrolled in a medical plan. Medical plans do not include Prescription Drug or Dental coverage. Separate selections are required.

Prescription Drug Coverage

CHOOSE ONE OPTION:
- New enrollment
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- Employee Only
- Employee & One Child
- Employee & Spouse
- Employee & Family

Dental Coverage

CHOOSE ONE OPTION:
- New enrollment
- Change in plan
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- Employee Only
- Employee & One Child
- Employee & Spouse
- Employee & Family

CHOOSE ONE DENTAL PLAN:
- United Concordia DPPO
- United Concordia DHMO

For the DHMO Plan: You must select a primary Dentist office once enrolled. Call plan or see plan website for details.

Accidental Death and Dismemberment Benefits

CHOOSE ONE OPTION:
- New enrollment
- Change of benefit amount
- Addition or removal of dependent
- No, I do not want to enroll in this benefit
- Cancel current coverage

CHOOSE ONE COVERAGE LEVEL:
- Employee Only coverage
- Family coverage

CHOOSE ONE BENEFIT AMOUNT:
- $100,000
- $200,000
- $300,000

Flexible Spending Accounts – SELECTED AMOUNTS ARE PER PAY CHECK

YOU MUST COMPLETE THIS SECTION IF YOU WANT TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT FROM JULY 2013-DECEMBER 2013. Due to federal regulations, same sex spouses and the dependent children of same sex spouses are not eligible for FSA participation.

<table>
<thead>
<tr>
<th>HEALTHCARE</th>
<th>DAY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHOOSE ONE OPTION:</td>
<td>CHOOSE ONE OPTION:</td>
</tr>
<tr>
<td>- Enroll in Healthcare Spending Account</td>
<td>- Enroll in Dependent Day Care Spending Account</td>
</tr>
<tr>
<td>- Change in Healthcare Spending Account</td>
<td>- Change in Dependent Day Care Spending Account</td>
</tr>
<tr>
<td>- No, I do not want to enroll in this benefit</td>
<td>- No, I do not want to enroll in this benefit</td>
</tr>
<tr>
<td>- Cancel Healthcare Spending Account</td>
<td>- Cancel Dependent Day Care Spending Account</td>
</tr>
</tbody>
</table>

$  $  $  $  $  $  $  $  $  $  Write in dollar amount per deduction

The short plan year affects your deduction amounts. See Benefits Guide for Minimum/Maximum deduction amounts. Check with your Agency Benefits Coordinator for your number of deductions. Reminder: This is not a yearly deduction amount. THIS IS THE AMOUNT PER DEDUCTION FOR JULY 2013-DECEMBER 2013.
ENROLLMENT FOR JULY 2013-DECEMBER 2013

**Life Insurance Plan**

**EMPLOYEE**

OPTIONS: Choose only one
- Yes, I want to enroll as a new employee in Life Insurance.
- I am currently enrolled in Life Insurance and making a change.
- No, I do not want Life Insurance for myself.
- Cancel Life Insurance.

Choose a Coverage Amount in increments of $10,000 up to $300,000:

STOP: If you choose an amount greater than $50,000, you must fill out a Life Insurance Evidence of Insurability form. Please go to our website www.dbm.maryland.gov to download the Evidence of Insurability form. Amount over $50,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

| $ | 0 | 0 | 0 | 0 |

**SPOUSE**

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. You cannot select an amount for your dependents greater than 50% of the amount selected for yourself.

OPTIONS: Choose only one
- Having selected Life Insurance for myself, I wish to have Life Insurance on my spouse.
- I currently have Life Insurance for my spouse and am making a change.
- No, I do not want Life Insurance on my spouse.
- Cancel Life Insurance on my spouse.

Choose a Coverage Amount in increments of $5,000 up to 1/2 of the amount chosen for yourself, up to $150,000:

STOP: If you choose an amount greater than $25,000, you must fill out a Life Insurance Evidence of Insurability for your spouse. Please go to our website www.dbm.maryland.gov to download the Evidence of Insurability form. Amount over $25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

| $ | 0 | 0 | 0 | 0 |

**CHILDREN**

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. You cannot select an amount for your dependents greater than 50% of the amount selected for yourself.

OPTIONS: Choose only one
- Having selected Life Insurance for myself, I wish to have Life Insurance for my children.
- I currently have Life Insurance for my children and am making a change.
- No, I do not want Life Insurance on my children.
- Cancel Life Insurance on my children.

Choose a Coverage Amount in increments of $5,000 up to 1/2 of the amount chosen for yourself, up to $150,000:

STOP: If you choose an amount greater than $25,000, you must fill out a Life Insurance Evidence of Insurability for each covered child. Please go to our website www.dbm.maryland.gov to download the Evidence of Insurability form. Amount over $25,000 will not be effective until we receive approval from our life insurance carrier.

Fill in the amount of Benefit

| $ | 0 | 0 | 0 | 0 |

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**Employee Signature**

Please enroll me for the benefits indicated on this form. I understand the benefits and limitations provided by the various plans and I authorize the State of Maryland to make the necessary adjustments in my pay based on the choices I have made. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or my dependents.

The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget and Management (DBM) regulations. I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a change in status permitted by COMAR 17.04.13.04.

I understand that if I have enrolled in one or both of the Flexible Spending Accounts, that I may seek reimbursement for services incurred through March 15, 2014 by filing for reimbursement by April 15, 2014 in order to avoid losing my contributions, and that my decision to deposit funds in the Spending Accounts is binding through December 31, 2013 and can only be modified if there is a qualifying change in status permitted by Section 125 of the Internal Revenue Code.

I understand that the benefits program offered by the State is subject to modifications and changes that the benefits I have chosen on this enrollment form are only in effect for JULY 2013-DECEMBER 2013. The State of Maryland reserves the right to modify any of the benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond December 31, 2013. I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for which I or they are enrolled on this form.

I certify that I and any dependents listed for coverage are eligible for coverage. I understand that enrollment in benefits to which I or my dependents are not entitled is considered fraud. In all cases I am responsible for the accuracy of my benefits, coverage levels and deductions. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my benefits application, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be canceled. I may be required to repay any claims and insurance premiums which have been paid inappropriately. I may face charges for dismissal from state service, and I may face criminal investigation and prosecution.

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact the plan's member service department before signing this application. Plan phone numbers are listed on the inside front cover of the Benefits Guide.

Is there any other health insurance coverage in which you, your spouse, or any of your dependents are enrolled? Yes No

Effective Date:__/__/____

Specify who is covered, name of insurance company and policy number:

I certify that I have discussed a Retroactive Adjustment with my Agency Benefits Coordinator.

Employee Signature: ____________________________ Date:__/__/____

**Agency Signature - Agency Must Sign Here**

I hereby certify that the person applying for enrollment is employed by the Agency. I certify that I have discussed a Retroactive Adjustment with the employee and have reviewed the form and accompanying documents for accuracy.

Agency Benefits Coordinator: ____________________________ Date:__/__/____

Work Phone Number (Ext.): ____________________________ Department: ____________________________

Agency Benefits Coordinator Email Address: ____________________________

Fax Number: ____________________________

SATACTEN02
STATE OF MARYLAND AFFIDAVIT of STATUS FOR ALL DEPENDENT CHILDREN

Name of Employee/Retiree:  
Last  
First  
M.I.

Employee's/Retiree's Social Security Number:  

Name of Dependent (hereafter, "Dependent" or "Child"):  
Last  
First  
M.I.  
Social Security Number:  

Dependent's Date of Birth:  

PART I.

A. Initial the box for the statement below that describes your relationship to the Dependent and go to Section B. If none apply, this person is NOT an eligible dependent and cannot be added to your health benefits coverage.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Dependent is my biological child.</td>
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</tr>
<tr>
<td>The Dependent is my adopted child OR a child placed with me for adoption by me.</td>
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</tr>
<tr>
<td>The Dependent is my stepchild.</td>
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</tr>
<tr>
<td>The Dependent is my grandchild.</td>
<td></td>
</tr>
<tr>
<td>The Dependent permanently resides with me and I am his/her testamentary or court-appointed guardian for a non-temporary guardianship of not less than 12 months.</td>
<td></td>
</tr>
<tr>
<td>The Dependent is related to me by blood or marriage, permanently resides with me and I provide his/her sole support.</td>
<td></td>
</tr>
</tbody>
</table>

B. If the Dependent is not married, initial the box below and go to Section C. If the Dependent is married, he/she is NOT an eligible dependent and cannot be added to your health benefits coverage.

The Dependent is not married.

C. Initial the box for the statement below that describes the Dependent and go to PART II. If neither statement describes the Dependent, this person is NOT an eligible dependent and cannot be added to your health benefits coverage.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Dependent is under the age of 25.</td>
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</tr>
<tr>
<td>The Dependent is any age and is incapable of self-support because of a mental or physical incapacity incurred before reaching age 25 and is chiefly dependent on me for support.</td>
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</tbody>
</table>

PART II. The Dependent must meet all tax criteria for Qualifying Child or Qualifying Relative. Initial the box for each criteria that is true for this Dependent. If you cannot initial all four Qualifying Child OR all three Qualifying Relative criteria this person is NOT an eligible dependent and cannot be added to your health benefits coverage.

**Qualifying Child Test**: Initial each criteria that applies to the Dependent - must meet all four

1. The child is my biological child or adopted child (or placed for adoption by me), my legal ward or child placed with me under court order (not temporary for less than 12 months), my step-child, sibling, or a descendent of my child or sibling (i.e., my grandchild, niece, nephew, etc.); and

2. The child lives with me for more than half of the year (more than six months) or is my biological or adopted child and meets the following residence exception:
   - The child receives over half of the child's support during the calendar year from the child's parents, who (1) are divorced or legally separated under a decree of divorce or separate maintenance, or (2) are separated under a written separation agreement, or (3) live apart at all times during the last six months of the calendar year; and
   - The child is in the custody of one or both of the child's parents for more than half of the calendar year; and

3. The child (1) has not attained age 19 as of the close of the calendar year(s) in which coverage is provided, or (2) is a full-time student for at least five months of the calendar year who has not attained age 24 as of the end of the calendar year(s) in which coverage is provided, or (3) is permanently and totally disabled; and

4. The child has not provided more than half of the child's own support for the calendar year(s) in which coverage is provided.

**Qualifying Relative Test**: Initial each criteria that applies to the Dependent - must meet all three

1. The Dependent has a specified relationship to me: my biological child, my adopted child (or placed for adoption by me), my step-child, my grandchild, my niece, my nephew, my sibling, or a person who is not my lawful spouse who lives with me and is a member of my household for the entire year (this includes a legal ward); and

2. I provide over half of the Dependent's support for the calendar year(s) in which coverage is provided; and

3. The Dependent is not my or anyone else's qualifying child (see test above) for the tax year(s) in which coverage is provided.

I solemnly affirm under the penalties of perjury that the contents of this paper are true regarding the Dependent to the best of my knowledge, information and belief. Refer to the reverse side (Page 2) for the required Dependent Documentation to confirm the information above.

Employee's/Retiree's Signature: ___________________________  
Date: ___________________________
**DEPENDENT DOCUMENTATION**

Employee’s/Retiree’s Name: ____________________________  Dependent’s Name: ____________________________

Refer to the list below for the documentation required to confirm the eligibility of the Dependent listed above. Write your initials in the appropriate box(es) below to indicate the documents attached to this form. Submit the Affidavit and documents along with your Enrollment Form to your Agency Benefits Coordinator (for Active/Satellite Employees) or to the Employee Benefits Division (for Retirees/Beneficiaries and Direct Pay Enrollees).

### Biological Child
- Copy of Child’s Official State Birth Certificate

### Adopted Child (or a child placed with you for adoption by you)
- Copy of Adoption papers required; must indicate child’s date of birth (see Benefits Book for more information regarding pending adoptions)

### Stepchild
- Copy of Child’s Official State Birth Certificate (must name spouse of employee/retiree as the child’s parent)
- Copy of Employee’s/Retiree’s Official State Marriage Certificate

### Grandchild
- Copy of Child’s Official State Birth Certificate
- Copy of Child’s Parent’s Birth Certificate (to document grandchild’s relationship to the employee/retiree)

### Legal Ward, Testamentary or Court appointed guardianship (not temporary for less than 12 months)
- Copy of Dependent’s Official State Birth Certificate
- Proof of Permanent Residency; see acceptable documents noted below:
  - Valid Driver’s License or Age of Majority Card, school records certifying Dependent’s address, day care records certifying Dependent’s address, Tax Documents certifying address with child’s name listed on Tax Document.
- Copy of Legal Ward/Testamentary Court Document, signed by a Judge

### Other Child Relative (includes step-grandchildren)
- Copy of Child’s Official State Birth Certificate
- Proof of Permanent Residency; see acceptable documents noted below:
  - Valid Driver’s License or Age of Majority Card, school records certifying Dependent’s address, day care records certifying Dependent’s address, Tax Documents certifying address with child’s name listed on Tax Document.
  - Sole Support Affirmation: I certify by my signature below that the dependent child listed on the reverse side of this form is supported solely by me.

### Disabled Adult Child
- Disability Certification Form (in addition to applicable documentation listed above)

Employee’s/Retiree’s Signature ____________________________  Date __________
AFFIDAVIT OF COMPLIANCE
02/07/2013.

Concerning: ____________________________ / ____________________________

PLEASE PRINT Family name, first name UID

Temporary I.D. Number Assigned: ____________________________

Have you ever applied for a Social Security Number (SSN) or an Individual Taxpayer's Identification Number *(ITIN)?

☐ Yes, my number is ____________________________

(Please attach a copy of your SSN or ITIN card to this form).

☐ Yes, but I have not received the number yet. * Please attach a copy of the Social Security Administration (SSA) receipt (if available) or a copy of your completed application for a SSN (if available) or a copy of your completed W-7 (for fellowships and honorariums only) to this form.

☐ NO. Please apply immediately for a SSN or ITIN.

________________________________________________________________________

(Signature) ____________________________ (Date) ____________________________

*(ITINs are not valid for employment. Only those NRAs who receive a fellowship ONLY or those NRAs receiving an honorarium should apply for an ITIN.

Department certification

I, the undersigned, on behalf of the University of Maryland, have complied with Treasury Regulation Section 301.6109 1(c), regarding taxpayer identification numbers. Although requests have been made, the above nonresident alien has not provided the University of Maryland, ____________________________ (campus location) with a valid taxpayer identification number (Social Security Number or Individual Taxpayer Identification Number).

(Signature of DEPARTMENT'S payroll representative) ____________________________ (Date) ____________________________
PERSONAL INFORMATION CHANGE FORM

Please complete this form to update the information we have on file for you at the Employee Benefits Division. This Personal Information Change Form can also be found on the Department of Budget and Management website at www.dbm.maryland.gov/benefits then click on Forms. The completed form can be faxed to 410-333-7104 or mailed to:

Department of Budget & Management
Employee Benefits Division
301 W. Preston Street
Room 510
Baltimore, Maryland 21201

Status (please check one):  Active Employee: _____  Satellite Employee: _____  Direct Pay: _____  Retiree: _____

EMPLOYEE/RETIREE SOCIAL SECURITY NUMBER: __________________________

NAME: ____________________________________________  (Last Name)
(First Name)  (M.I.)

If Name Change:
NEW NAME: ____________________________________________  (Last Name)
(First Name)  (M.I.)

IMPORTANT: Legal proof of name change MUST be attached to this form

STREET ADDRESS: ____________________________________________

CITY: __________________________  STATE: __________  ZIP: __________

DATE OF BIRTH: __________________________

WORK PHONE: __________________________  HOME PHONE: __________________________

CELL PHONE: __________________________

PERSONAL EMAIL ADDRESS: __________________________

WORK EMAIL ADDRESS: __________________________

________________________  __________________________
Employee/Retiree Signature  Date

Note: This Personal Information Change Form is only for use within the Employee Benefits Division. If your personal information is not correct with the Central Payroll Bureau or the Maryland State Retirement Agency, those agencies need to be contacted independently as a separate form is required.