Instructions for Completing Permanent Data Forms

You must complete a Permanent Data Form if you are a new Participant, if you are adding a Dependant, if your marital status changes, or if your dependant's eligibility status changes.

The following documents must be included with your completed Permanent Data Form:

Married

- If you are married – a copy of your marriage certificate.
- If your spouse has other coverage, please forward a copy of your spouse's medical/dental/optical insurance card(s), so that the Plan can properly coordinate benefits.

Children

- Biological children – a copy of each child's birth certificate.
- Adopted children – a copy of each child's adoption papers and birth certificate.
- Stepchildren – a copy of each child's birth certificate, a copy of your most recent IRS tax filing, a copy of that part of your spouse's divorce decree that assigns responsibility for the stepchild's medical care.
- Grandchildren - a copy of each child's birth certificate, proof of legal custody awarded by a court or state agency, a copy of your most recent IRS tax filing, (additional documentation may be required).

Dependant Parents

- Dependant Parents – a copy of your most recent IRS tax filing as proof that you claim your parent as a dependant on your tax return. You will be required to provide proof of support of your parent(s) annually.

Your parent(s) may be covered as a dependant only if:

(1) you do not have a spouse, you do not have natural or adopted children under the age of 26, and you do not have stepchildren under age 19 (or 23, if full-time students); and

(2) you contribute at least one-half of the support of the parent being claimed as a dependant, claim your parent as a dependant on your IRS tax return, and you submit a copy of your most recent IRS tax filing as proof of support.

Additional Requirements for Adult Children (over age 18)

Biological and Adopted Children Age 19 through 25

- Your biological and adopted adult children under the age of 26 may be covered as a dependant.

Stepchildren and Grandchildren

- Your stepchildren and grandchildren age 19 through age 22 may be covered as a dependant provided they are full-time students.
- Student status forms are available from the Plan Office or on the Plan website (www.mebaplans.org).
- You are required to verify full-time student status for each stepchild and/or grandchild each year.

If you or any of your dependents are eligible for Medicare, you must provide a copy of you and/or your dependent's Medicare card.

Change in Marital Status

Marriage

- If you are single and become married, you must notify the Plan Office and submit a copy of your marriage certificate with your new Permanent Data Form to enroll your new spouse.

Divorce or legal separation

- If you are married and become divorced or legally separated, you must notify the Plan Office immediately and submit a copy of your divorce decree, legal separation agreement or your written agreement to live separately within 30 days, along with your new Permanent Data Form.

- If you are divorced and are keeping your children as dependants in the Plan, you must provide additional information about other coverage the children may have, such as through your former spouse (or his or her new spouse, if remarried), so that the Plan can properly coordinate benefits. If included in your divorce decree, a copy of the portion that assigns responsibility for medical care may be needed to determine order of payment.

Address and Address Changes

- If you use a PO Box as either your permanent address or your mailing address, you must also provide a physical address.
- If you are advising the Plan of a change of address only and have no other changes to make you can complete a new Permanent Data Form or you can simply notify the Plan Office in writing of the address change. Include your name and social security number. The Participant must sign this notification in order to allow the Plan Office to change your address.

IMPORTANT - When Coverage Terminates

If you and/or your dependant no longer meet the eligibility requirements your coverage and/or your dependant's coverage will end. You are required to notify the Plan Office in writing and within 30 days of events that impact your and/or your dependant's eligibility under the Plan. Events that may lead to ineligibility and a loss of coverage under the Plan include, but are not limited to:

- Failure to report a divorce;
- Failure to report a legal separation;
- Failure to report a child's eligibility for other coverage, including the availability of such coverage;
- For stepchildren and grandchildren, failure to report a change in student status, a change in residency or a change in support;
- For stepchildren and grandchildren, failure to report a child's marriage;
- For grandchildren, failure to meet the grandchild eligibility rules; and
- Failure to pay any required premiums (e.g., COBRA, pensioner contributions, Alternate Plan premiums) timely.
- For Pensioners, return to work under certain circumstances without the permission of the Trustees.

If you do not timely notify the Plan Office of an event that causes a change in your or your dependant's eligibility under the Plan, you will be required to reimburse the Plan for benefits that were paid after your and/or your dependant's coverage terminated.

In addition, your or your dependant's coverage under the Plan may be terminated retroactively in the case of fraud or intentional misrepresentation.

MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (6322) * 410-547-6665 (Fax) * www.mebaplans.org

PERMANENT DATA FORM

COMPLETE BOTH PAGES OF THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name	Last Name First Name Initial		
Social Security Number			
Date of Birth (mm/dd/yyyy)		Sex (Select one)	○ Male ○ Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	☐ District No. 1-PCD, MEBA ☐ Plan Employee ☐ Union Employee ☐ Other:		
Active/Pensioner (Check One)	☐ Active ☐ Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		
Date Married, Widowed, Divorced or Legally Separated (mm/dd/yyyy)		☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated	
Permanent Address (Home of Record):	Number & Street		
	City, State, Zip		
Mailing Address (if different than Permanent Address above):	Number & Street		
	City, State, Zip		

DEPENDANTS TO BE ADDED TO YOUR MEDICAL COVERAGE (LIST FULL NAMES)

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			☐ Spouse ☐ Child ☐ Adopted Child ☐ Stepchild ☐ Grandchild	☐ Yes ☐ No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐ Yes ☐ No..
If eligible for Employment Based Coverage, complete the following sections

Child's Employer Name	Child's Employer Address	Child's Employer Phone
Child's Spouse's Employer Name	Child's Spouse's Employer Address	Child's Spouse's Employer Phone

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LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐ Yes ☐ No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐Yes ☐No..
If eligible for Employment Based Coverage, complete the following sections

Child's Employer Name	Child's Employer Address	Child's Employer Phone
Child's Spouse's Employer Name	Child's Spouse's Employer Address	Child's Spouse's Employer Phone

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐ Yes ☐ No

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If eligible for Employment Based Coverage, complete the following sections

Child's Employer Name	Child's Employer Address	Child's Employer Phone
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LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐ Yes ☐ No

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Child's Employer Name	Child's Employer Address	Child's Employer Phone
Child's Spouse's Employer Name	Child's Spouse's Employer Address	Child's Spouse's Employer Phone

(Attach a separate sheet to your Permanent Data Form if you have more than four Dependants)

Signature of Employee		Date	

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.

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