Retiree Benefits Change Form
Plan year July 1, 2026 - June 30,2027

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

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

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

COVERED SPOUSE AND DEPENDENT(S) INFORMATION

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

FIRST NAME MI LAST NAME	RELATIONSHIP	BIRTH DATE	PLAN TYPE Check one or all	GENDER M/F	SOCIAL SECURITY NUMBER
	Spouse		Medical ☐ Dental ☐ Vision ☐		**xxx-xx-**
	Child		Medical ☐ Dental ☐ Vision ☐		**xxx-xx-**
	Child		Medical ☐ Dental ☐ Vision ☐		**xxx-xx-**

AUTHORIZATION – I understand that should I cancel my medical coverage (includes prescription drug), dental, or vision coverage, I cannot re-enroll at a later date.

Signature _____ Date _____