SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM

BLUE Preferred

THIS IS NOT AN APPLICATION FOR INSURANCE

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065

1 EMPLOYER INFORMATION: To be completed by the employer.

Employer/Group Administrator

Group Number:

Medical: _____ Dental: _____

Effective Date Requested __ __/__ __/__ __

Medical Option: _____ Vision: _____

Check all that apply

Employment Status: ☐ Active ☐ Full Time ☐ Part Time

2 TYPE OF REQUEST

☐ New Subscriber ☐ Coverage Change ☐ Add Dependents ☐ Delete Dependents

☐ Any information change (name or address change)

Are you enrolling eligible dependents?

☐ Yes ☐ No

3 SUBSCRIBER INFORMATION

Social Security Number	Subscriber Last Name	First Name	Middle Initial
__ __ __ - __ __ - __ __ __ __			

Date of Birth	Sex:	Date of Hire:	Marital Status:
__ __/__ __/__ __	☐ Male ☐ Female	__ __/__ __/__ __	☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed Effective Date of Status __ __/__ __/__ __

Street Address	Apt.	City	County	State

Country	Zip	Home Phone	Work Phone
		( ) __ __ __ - __ __ __ __	( ) __ __ __ - __ __ __ __

4 SUBSCRIBER & DEPENDENT INFORMATION: Please list all persons to be covered.

COVERAGE LEVEL – Please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section, to avoid delays in processing this Enrollment Form.

COVERAGE LEVELS OF SUBSCRIBER AND DEPENDENTS, IF APPLICABLE

Coverage Level for Medical Option:

☐ Individual ☐ Individual and Adult ☐ Individual and Child(ren) ☐ Family

Coverage Level for Dental Option (if applicable and your employer has elected to offer):

☐ Individual ☐ Individual and Adult ☐ Individual and Child(ren) ☐ Family

Coverage Level for BlueVision *Plus* Option (if applicable and your employer has elected to offer):

☐ Individual ☐ Individual and Adult ☐ Individual and Child(ren) ☐ Family

SUBSCRIBER INFORMATION

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Traditional Dental ☐ Preferred Dental ☐ BlueVision *Plus*	Subscriber			

DEPENDENT INFORMATION: If the subscriber has more than four dependents, please list the additional dependents on a separate enrollment form.

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Dental ☐ BlueVision *Plus*				
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Dental ☐ BlueVision *Plus*				
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Dental ☐ BlueVision *Plus*				
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Dental ☐ BlueVision *Plus*				

Is anyone listed above a student or disabled? ☐ YES ☐ NO

If the answer is YES, please list the name of the person _____

If a full-time student, please attach student certification form. If yes, disabled, please attach disability certification form and supporting documentation.

CUT5416-9S (4/05)

Blue Preferred

5 MEDICARE INFORMATION: To be completed if applicable.

		Medicare Number	Hosp. Eff. Date (Part A)	Med. Eff. Date (Part B)
Are You Eligible for Medicare?	☐ Yes ☐ No	If Yes: __ __ __ - __ __ - __ __ __ __ - __ __	__ __/__ __/__ __	__ __/__ __/__ __
Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled	
Spouse/Partner?	☐ Yes ☐ No	If Yes: __ __ __ - __ __ - __ __ __ __ - __ __	__ __/__ __/__ __	__ __/__ __/__ __
Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled	
Child/Dependent?	☐ Yes ☐ No	If Yes: __ __ __ - __ __ - __ __ __ __ - __ __	__ __/__ __/__ __	__ __/__ __/__ __
Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled	

6 OTHER HEALTH INSURANCE INFORMATION

IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

Is any person listed on the enrollment form covered by another health care plan, HMO, or Medicare? ☐ Yes ☐ No

If yes, will this coverage be continued? ☐ Yes ☐ No If no, please provide the cancellation date __ __/__ __/__ __

Policyholder's Name	Phone Number of Other Insurer	Date of Birth
	( ) __ __ __ - __ __ __ __	__ __/__ __/__ __

Name and Address of Insurance Company

Policy Number	Termination Date	Effective Date of Policy
	__ __/__ __/__ __	__ __/__ __/__ __

Services Covered: ☐ Hospital Services ☐ Physician Services ☐ Major Medical ☐ Drug Program

☐ Dental Services ☐ Eye/Vision Care Services ☐ HMO ☐ Mental Illness Services

Does this policy cover you? ☐ Yes ☐ No Your Spouse/Partner? ☐ Yes ☐ No Your children? ☐ Yes ☐ No

Please list name(s) of children covered _____

Is this coverage under COBRA? ☐ Yes ☐ No If yes, reason for cancellation _____

_____ Cancellation Date __ __/__ __/__ __

I hereby enroll, on behalf of myself and each dependent listed above, for the health coverage indicated. If this Form is accepted, coverage will be provided according to terms and conditions of the health care contract between CareFirst BlueCross BlueShield and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution.

I have carefully read this Form and agree to its terms. The recorded answers on this Form are, to the best of my knowledge and belief, full, complete and true as of this date.

THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE ANY SECTION MAY DELAY CLAIMS PAYMENT.

_____ __ __/__ __/__ __ _____ __ __/__ __/__ __

Subscriber's Signature Date Dependent's Signature Date

_____ __ __/__ __/__ __

Authorization Signature Date

CUT5416-9S (4/05)

SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM

Select Preferred

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CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065

1 EMPLOYER INFORMATION: To be completed by the employer.

Employer/Group Administrator	Group Number:
	Medical: _____ Dental: _____
Effective Date Requested __ __/__ __/__ __	Medical Option: _____ Vision: _____

Check all that apply

Employment Status: ☐ Active ☐ Full Time ☐ Part Time

2 TYPE OF REQUEST

☐ New Subscriber ☐ Coverage Change ☐ Add Dependents ☐ Delete Dependents

☐ Any information change (name or address change)

Are you enrolling eligible dependents? ☐ Yes ☐ No

3 SUBSCRIBER INFORMATION

Social Security Number	Subscriber Last Name	First Name	Middle Initial
__ __ __ - __ __ - __ __ __ __			

Date of Birth	Sex:	Date of Hire:	Marital Status:
__ __/__ __/__ __	☐ Male ☐ Female	__ __/__ __/__ __	☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed Effective Date of Status __ __/__ __/__ __

Street Address	Apt.	City	County	State

Country	Zip	Home Phone	Work Phone
		( ) __ __ __ - __ __ __ __	( ) __ __ __ - __ __ __ __

4 SUBSCRIBER & DEPENDENT INFORMATION: Please list all persons to be covered.

COVERAGE LEVEL – Please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section, to avoid delays in processing this Enrollment Form.

COVERAGE LEVELS OF SUBSCRIBER AND DEPENDENTS, IF APPLICABLE

Coverage Level for Medical Option:
☐ Individual ☐ Individual and Adult ☐ Individual and Child(ren) ☐ Family

Coverage Level for Dental Option (if applicable and your employer has elected to offer):
☐ Individual ☐ Individual and Adult ☐ Individual and Child(ren) ☐ Family

Coverage Level for BlueVision *Plus* Option (if applicable and your employer has elected to offer):
☐ Individual ☐ Individual and Adult ☐ Individual and Child(ren) ☐ Family

SUBSCRIBER INFORMATION

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Traditional Dental ☐ Preferred Dental ☐ BlueVision *Plus*	Subscriber			

DEPENDENT INFORMATION: If the subscriber has more than four dependents, please list the additional dependents on a separate enrollment form.

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Dental ☐ BlueVision *Plus*				
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Dental ☐ BlueVision *Plus*				
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Dental ☐ BlueVision *Plus*				
		☐ Add ☐ Change ☐ Delete	☐ Medical ☐ Dental ☐ BlueVision *Plus*				

Is anyone listed above a student or disabled? ☐ YES ☐ NO
If the answer is YES, please list the name of the person _____
If a full-time student, please attach student certification form. If yes, disabled, please attach disability certification form and supporting documentation.

CUT5416-9S (4/05)

Select Preferred

5 MEDICARE INFORMATION: To be completed if applicable.

Are You Eligible for Medicare?	☐ Yes ☐ No	Medicare Number If Yes: __ __ __ - __ __ - __ __ __ __ - __ __	Hosp. Eff. Date (Part A) __ __/__ __/__ __	Med. Eff. Date (Part B) __ __/__ __/__ __
	Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled
Spouse/Partner?	☐ Yes ☐ No	Medicare Number If Yes: __ __ __ - __ __ - __ __ __ __ - __ __	Hosp. Eff. Date (Part A) __ __/__ __/__ __	Med. Eff. Date (Part B) __ __/__ __/__ __
	Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled
Child/Dependent?	☐ Yes ☐ No	Medicare Number If Yes: __ __ __ - __ __ - __ __ __ __ - __ __	Hosp. Eff. Date (Part A) __ __/__ __/__ __	Med. Eff. Date (Part B) __ __/__ __/__ __
	Reason for Entitlement:	☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled

6 OTHER HEALTH INSURANCE INFORMATION

IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

Is any person listed on the enrollment form covered by another health care plan, HMO, or Medicare? ☐ Yes ☐ No

If yes, will this coverage be continued? ☐ Yes ☐ No If no, please provide the cancellation date __ __/__ __/__ __

Policyholder's Name	Phone Number of Other Insurer	Date of Birth
	( ) __ __ __ - __ __ __ __	__ __/__ __/__ __

Name and Address of Insurance Company

Policy Number	Termination Date	Effective Date of Policy
	__ __/__ __/__ __	__ __/__ __/__ __

Services Covered: ☐ Hospital Services ☐ Physician Services ☐ Major Medical ☐ Drug Program
☐ Dental Services ☐ Eye/Vision Care Services ☐ HMO ☐ Mental Illness Services

Does this policy cover you? ☐ Yes ☐ No Your Spouse/Partner? ☐ Yes ☐ No Your children? ☐ Yes ☐ No

Please list name(s) of children covered _____

Is this coverage under COBRA? ☐ Yes ☐ No If yes, reason for cancellation _____

_____ Cancellation Date __ __/__ __/__ __

I hereby enroll, on behalf of myself and each dependent listed above, for the health coverage indicated. If this Form is accepted, coverage will be provided according to terms and conditions of the health care contract between CareFirst BlueCross BlueShield and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution.

I have carefully read this Form and agree to its terms. The recorded answers on this Form are, to the best of my knowledge and belief, full, complete and true as of this date.

THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE ANY SECTION MAY DELAY CLAIMS PAYMENT.

_____ __ __/__ __/__ __ _____ __ __/__ __/__ __
Subscriber's Signature Date Dependent's Signature Date

_____ __ __/__ __/__ __
Authorization Signature Date

CUT5416-9S (4/05)

CareFirst BlueChoice

CareFirst BlueCross BlueShield

Waiver of Enrollment Form

Employee Name_____ Social Security Number_____

Group Name_____ Group Number_____

Employment date_____

I certify that the health protection plan of CareFirst BlueCross BlueShield/CareFirst BlueChoice has been explained to me and at this time I choose:

☐ Not to enroll or,	FOR	myself and my dependents, (if any)
☐ If enrolled, to cancel coverage		my dependents only

The other coverage is (select one):

- ❑ Commercial Insurance Policy (employer sponsored only)
- ❑ Spouse's group health benefit plan
- ❑ CHAMPUS
- ❑ Medicare as primary under TEFRA
- ❑ COBRA

Note that coverage through an individual policy is not considered a valid reason for waiver.

Please check which benefits you and/or your dependents have with the other carrier.

- ❑ Medical
- ❑ Dental
- ❑ Vision

I understand that if I decide later to enroll myself and/or dependents, all such late enrollees will be subject to the special enrollment requirements, as detailed on the next page. I declare that the information I have furnished above, to the best of my information and belief, is true, correct and complete.

Signature of Employee_____ Date_____

CUT6529-1E (3/04)

You or your dependent(s) are not considered Late Enrollees when you or your dependent(s) are covered under your spouse's or parent's coverage through another group and:

a) You and/or your dependent(s) are not longer eligible under your spouse's coverage because your spouse's employment or his or her group has been terminated;

b) You are no longer eligible or included under your spouse's coverage due to legal separation or divorce;

c) Your dependent is no longer eligible or included under your spouse's coverage due to legal separation or divorce or the dependent's age;

d) You and/or your dependent(s) are no longer eligible under your spouse's coverage due to the death of your spouse;

e) You are no longer eligible under your parent's coverage;

f) You and/or your dependent(s) have coverage through another group but later become ineligible for coverage through that group (including COBRA participants).

In the above situations, you will not be treated as a Late Enrollee, provided you and/or your eligible dependent(s) enroll within 31 days of the termination date of your prior coverage and submit, as necessary, a letter from your spouse's former employer. This letter must indicate when the spouse's employment terminated, whether the spouse's employment terminated, when the spouse's coverage terminated, whether the spouse was enrolled under individual or family coverage, and a statement indicating that the employer contributed toward the cost of coverage. A similar letter is also required for dependents that are no longer eligible under their parent's coverage. Please contact your Group Administrator if you have any questions about these enrollment requirements.

Please return this form to:

CareFirst BlueCross BlueShield / CareFirst BlueChoice, Inc.
Enrollment & Billing
10455 Mill Run Circle
Owings Mills, MD 21117
Mail Stop 02-330