SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM

THIS IS NOT AN APPLICATION FOR INSURANCE

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: ☐ Male ☐ Female

Date of Hire: __ __ /__ __ /__ __

Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed

Effective Date of Status __ __ /__ __ /__ __

Street Address | Apt. | City | County | State

Country | Zip

Home Phone ( ) __ __ __ - __ __ __ __

Work Phone ( ) __ __ __ - __ __ __ __

4 COVERAGE LEVEL: 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.

TYPE OF COVERAGE ☐ BluePreferred ☐ SPPP ☐ HRA Compatible ☐ HSA Compatible ☐ HRA BlueFund

COVERAGE LEVELS OF SUBSCRIBER AND DEPENDENTS, IF APPLICABLE

Coverage Level for Medical Option:

☐ Individual ☐ Individual and Adult ☐ Individual and Child(ren) ☐ Family ☐ Coverage Complimentary to Medicare (Individual Only)

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

5 SUBSCRIBER & DEPENDENT INFORMATION

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

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 (10/07)

6 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	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

7 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

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

CUT5416-9S (10/07)