SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM

840 First Street, NE
Washington, DC 20065

1 EMPLOYER INFORMATION

Employer/Group Administrator

Group Numbers:
BlueChoice ____________ Dental ____________
Vision ____________ Other ____________

Effective Date Requested __ __ /__ __ /__ __

Check all that apply
Employment Status: ☐ Active ☐ Full Time ☐ Part Time ☐ Retired

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 ☐ Divorced ☐ Separated ☐ Widowed
Effective Date of Marital Status __ __ /__ __ /__ __

Street Address | Apt. | City | County | State

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

4 COVERAGE LEVEL

Coverage Level:
☐ Individual ☐ Parent and Child
☐ Husband/Wife ☐ Family

Coverage Selected: **Check only those options that your employer has elected to offer.**

☐ BlueChoice ☐ BlueChoice Opt-Out ☐ BlueChoice Opt-Out *Plus*
☐ Dental HMO ☐ Traditional Dental ☐ BlueVision *Plus*
☐ Dental HMO Opt Out ☐ Preferred Dental

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

List the primary care physician for each person and indicate if that person is currently a patient of that physician.

Last	First	MI		Relationship	Sex	Date of Birth	Social Security Number	Existing Patient	Disabled *	Student *	Primary Care Physician	PCP ID Number
			☐ Add ☐ Delete ☐ Change	Subscriber				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
			☐ Add ☐ Delete ☐ Change	Spouse				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
			☐ Add ☐ Delete ☐ Change	Dependent				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
			☐ Add ☐ Delete ☐ Change	Dependent				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
			☐ Add ☐ Delete ☐ Change	Dependent				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
			☐ Add ☐ Delete ☐ Change	Dependent				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

***If yes, disabled, please attach disability certification form and supporting documentation.**

***If full time student, please attach student certification form.**

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6 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? ☐ 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 __ __/__ __/__ __ | Policy Covers ☐ Policyholder Only ☐ Two Person ☐ Family | Effective Date of Policy __ __/__ __/__ __

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

Does this policy cover you? ☐ Yes ☐ No Your spouse? ☐ 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 apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this application is accepted, coverage will be provided according to the terms and conditions of the contract between CareFirst BlueChoice and my employer. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I have carefully read this application and agree to its terms. The recorded answers on this application 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.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application.

______________________ __ __/__ __/__ __ ______________________ __ __/__ __/__ __

Subscriber's Signature Date Dependent's Signature Date

______________________ __ __/__ __/__ __

Authorization Signature Date

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