

**CareFirst BlueChoice, Inc.**

840 First Street, NE  
Washington, DC 20065  
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

**GROUP ENROLLMENT APPLICATION**  
**Maryland Small Group Business**

<p><input type="checkbox"/> <b>APPLICATION FOR GROUP ENROLLMENT</b> <b>(New Group)</b></p> <p>Please complete the entire application.</p>	<p><input type="checkbox"/> <b>APPLICATION FOR AMENDMENT</b> <b>(Existing Group)</b></p> <p>Fill in Name of Organization and Group Number. Complete only those areas in which information is changing.</p> <p>Group Number _____</p>
---	--

**Please sign and return this application to your Sales Representative.**  
**No retroactive effective dates for new groups or amendments will be permitted.**

Name of Organization: \_\_\_\_\_  
(Group) (Name as it appears above will be used in your Group Enrollment Agreement)

Physical Location: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip  
(Group location must be within the Plan's Service Area)

Mailing Address: \_\_\_\_\_  
(if other than above) Street  
\_\_\_\_\_  
City State Zip

Chief Executive Officer: \_\_\_\_\_  
Name Title Telephone No.

Group Administrator: \_\_\_\_\_  
(Person to Contact) Name Title Telephone No.

Nature of Business: \_\_\_\_\_  
(Please Specify)

Type of Organization  Sole Proprietor  Partnership  Other \_\_\_\_\_

Federal Tax Identification Number: \_\_\_\_\_

## Eligibility and Enrollment

**Group Eligibility Requirements** -- To be eligible for coverage and maintain its eligibility, the Group must meet all requirements for a Small Employer as provided under the Maryland Small Employer Insurance Business Reform Law. You must be a Maryland employer that employed at least 2 but not more than 50 Eligible Employees on 50% of your work days during the preceding calendar quarter; the majority of whom were employed within the State of Maryland. Small Employer also means non-profit organizations that are exempt from taxation under §501(c)(3), (4), or (6), of the Internal Revenue Code and employ at least one but not more than 50 Eligible Employees. In determining if the Group employs the requisite number of Eligible Employees, Part-Time Employees will not be included. However, an employer is considered to continue to be a Small Employer if the employer met the requirements for a Small Employer and subsequently eliminated all but one Eligible Employee.

A Small Employer who met the definition of a "Small Employer" will be permitted to renew their coverage for as long as the employer continues to meet the definition in effect on the date they originally applied for coverage. Your Sales Representative or broker can help you obtain additional detailed information about the requirements of the Maryland Small Employer Insurance Business Reform law.

**Eligible Employees** -- Eligible Employee means an employee who works on a full-time basis and has a normal workweek of 30 or more hours. Eligible Employee includes:

- a. A sole proprietor, a partner of a partnership, or an independent contractor, who is included as an employee under a health benefit plan under the Maryland Small Employer Insurance Business Reform Law; or
- b. A sole employee of a nonprofit organization, which has been determined by the Internal Revenue Service to be exempt from taxation under section 501(c)(3), (4), or (6) of the Internal revenue Code, who has a normal workweek of 20 or more hours and is not covered under a public or private health insurance plan or other health benefit arrangement.

Eligible Employee does not include an individual who works on a temporary or substitute basis or an individual who works for less than 30 hours in a normal workweek, except for an individual described in item b., above.

**Additional Eligibility Options** -- The Group may elect to cover Part-Time Employees and/or employees covered under another public or private plan of health insurance or other health benefit arrangement.

- Check here if you wish to cover **Part-Time Employees**.  
"Part-Time Employee" means an employee who has a normal workweek of at least 17½ hours a week, but less than 30 hours a week and has been continuously employed for at least four consecutive months.
- Check here if you wish to cover **Employees With Other Coverage**  
"Other Coverage" means another public or private plan of health insurance or other health benefit arrangement including Medicare, Medicaid or Champus, that provides benefits similar to or exceeding the benefits provided under this Group Agreement.

**Effective Date** -- Coverage for new Eligible Employees will be effective on the first day of the month following the date of hire unless otherwise specified below:

- the date of hire
- the first day of the month following 30 days of employment
- the first day of the month following 60 days of employment
- the first day of the month following 90 days of employment
- other: \_\_\_\_\_

**Minimum Enrollment Requirements** -- The Group must enroll and maintain enrollment of at least 75% of all Eligible Employees. To determine enrollment, the Plan considers all Eligible Employees, except those who have group spousal coverage under a public or private plan of health insurance, or a health benefit arrangement through another employer that provides benefits similar to or exceeding the benefits under this Group Agreement, including Medicare, Medicaid, and CHAMPUS or Part-Time employees. If the Group offers another health benefits program through the Plan and/or through another CareFirst affiliated or related entity, the total Group enrollment in all such plans will be combined to determine enrollment. The Plan may not impose a minimum participation requirement for a Small Employer Group if any Member of the Group participates in a medical savings account.



## Other Terms

**Rates and Coverage** -- Please attach the appropriate rate and benefit schedule for the coverage selected. This application cannot be processed without the schedule. If the actual enrollment varies from that used in the original rating such that the Group is not eligible for Maryland Small Employer Insurance Business Reform Law coverage, the Group will be required to apply for other coverage by completing a new application and will be charged different rates.

**Group Statements** -- The Group agrees that in submitting this application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The Group is not the agent or representative of the Plan for any purpose of this application or any Group Agreement issued pursuant to this application.

The Group agrees to receive on behalf of its Eligible Employees and their Dependents and COBRA participants, if applicable, Evidence of Coverage, the Identification Cards, and all relevant notices furnished by the Plan and to forward such materials to these individuals at their last known address.

Should any statements or answers contained in this application be untrue (if such statements are fraudulent or material to the acceptance of this application), then the contract may be canceled by the Plan, and the Plan's obligations shall consist only of the return of any subscription charges actually received by the Plan, less the amount of any benefits paid under the coverage.

Following approval of this application by the Plan Contract Administration Department, the Plan will issue a Group Enrollment Agreement if the Group is a new Group. If the Group is an existing Group, the Plan will either issue a new Group Agreement (if there are substantial changes) or amend your current Group Agreement. The Plan can amend your Group Agreement through acceptance and approval of this application or by issuing a new Rider or Endorsement to your Group Agreement.

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

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Chief Executive Officer of the Group)

Amount Enclosed: \$ \_\_\_\_\_ (For new groups only)

**Non-Binding Acceptance of Application, Subject To Final Approval By CareFirst BlueChoice, Inc.**

**By** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Signature of Broker or Sales Representative)

Broker or Rep. Code ID # \_\_\_\_\_

**CareFirst BlueChoice, Inc. Approval:**

**By** \_\_\_\_\_ **Date** \_\_\_\_\_  
Director, Contract Administration

**Effective Date of Group Coverage** \_\_\_\_\_

**ATTACHMENT A**  
**Description of Point-of-Service Options**

*A point-of-service option allows your employees to obtain health care services from physicians and other providers outside the HMO network under certain circumstances as described in the attached Riders.*