SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM

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

COVERAGE LEVEL – Please confirm with your employer the details of the benefit options 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

☐ Self ☐ Self and Child ☐ Self and Spouse ☐ Family

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

Coverage Level for BlueVision Plus Option (if applicable and your employer has elected to offer):
☐ Self ☐ Self and Child ☐ Self and Spouse ☐ 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 (6/04)

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? ☐ 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? ☐ 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 BlueCross BlueShield 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.

_____ _ _ / _ _ / _ _ _____ _ _ / _ _ / _ _

Subscriber's Signature Date Dependent's Signature Date

_____ _ _ / _ _ / _ _

Authorization Signature Date

CUT5416-9S (6/04)