EMPLOYEE ELECTION FORM

BenefitMall

THIS IS NOT AN APPLICATION FOR INSURANCE

☐ New Hire ☐ Re-Hire ☐ COBRA/Continuation (Group Administered) ☐ Add Coverage

BMLL Billing # _____
Effective Date _____
Team # _____
Carrier Group # (See Coverage Boxes)
Employer with 20 or more employees? ☐ Yes ☐ No

Last Name	First Name	M.I.	Employer
SURIKOV	Sergey	A	Webworld

Street Address	Social Security Number
9200 Copenhaver Dr.	230-51-7177

City	State	Zip	Gender	Date of Birth
Potomac	MD	20854	☒ Male ☐ Female	06/07/1957

Home Telephone #	Business Telephone #	Marital Status	Date of Marriage	Date Full-Time Employment Started:
(301) 340-8288	( )	☐ S ☒ M ☐ D ☐ W	07/10/1995	09/03/2013

Are you actively working for the employer listed above (as defined in your insurance contract)?
☒ Yes ☐ No ☒ Full-time ☐ Part-time

Hours Worked/Week: 40

Occupation: Software Engineer

Employee Class:

Annual Salary: $92,000

MEDICAL PLAN (if offered) [1]
Carrier _____
Plan Type _____
Carrier Group # _____
☐ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ Over 65 ☐Retired ☐Working
☐ Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)
☒ Waive Coverage*

DENTAL PLAN (if offered)
Carrier _____
Plan Type _____
Carrier Group # _____
☐ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☒ Waive Coverage*
Provider # _____
Name _____
Family Dentist**
Name _____
Office # _____

VISION PLAN (if offered)
Carrier _____
Carrier Group # _____
☐ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ Waive Coverage*

☐ LTD (if offered) ☒ Waive Coverage*
☐ VOL. LTD ☒ Waive Coverage*
Carrier _____
Benefit $ _____ /Mo.

☐ LIFE AND AD&D (if offered)
☐ Waive Coverage*
☐ VOL LIFE $ _____
☐ SPOUSE $ _____
☐ DEP. CHILD $ _____
Carrier _____

☐ STD (if offered) ☐ Waive Coverage*
☐ VOL. STD ☐ Waive Coverage*
Plan # _____
Benefit $ _____ / Wk.
Carrier _____

Life Insurance Beneficiary (if coverage offered)

Last, Full First, M.I.	Social Security Number	Birth Date	Sex	Student (Y/N)	Disabled (Y/N)	Relationship	For HMO and POS Plans: Primary Care &OBGyn Carrier Assigned Provider # and name	Existing Patient (Y/N)
Emp				N	N			
Sp								
Chd								
Chd								
Chd								

OTHER HEALTH INSURANCE: Please note: You must complete this section if waiving or enrolling in medical coverage and your company offers Dual Coverage OR if you are currently covered under Medicare.

Do you or your dependents have "health" coverage with another insurer? ☐No ☒ Yes *If Yes*: Effective Date: 01/01/2013
Other Carrier name/policy # BCBS 7893712948 Will this coverage be continued? ☒ Yes ☐ No *If No*: Term. Date: _____
Are you covered by Medicare? ☒No ☐ Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__ Medicare # _____
Is your spouse or dependent(s) covered by Medicare? ☒ No ☐ Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__
Name of spouse or dependent(s) covered (if applicable): _____ Medicare # _____

***Waiver of Coverage: I certify that group insurance coverage has been offered to me and I choose to waive coverage due to:**
☒ Spousal Coverage ☐ Individual Coverage ☐ Military Coverage ☐ COBRA ☐ Medicare as primary under TEFRA ☐ No Coverage

CERTIFICATION: I hereby certify that I am the spouse, parent or legal guardian of the dependent(s) shown above. ***Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.***

- **Voluntary benefits may be subject to pre-existing condition exclusions (please refer to your policy for more information).**

I authorize my employer to make any necessary payroll deductions and also declare that any disability coverage in force and applied for, with respect to myself, is less than 75% of my current monthly earnings (60% for intermediate disability income).

EMPLOYEE SIGNATURE _____ **DATE** 08/14/2013

EMPLOYER SIGNATURE/VERIFICATION _____ **DATE** _____

[1] If enrolling in HMO coverage, please refer to the "Waiver of Insurance Coverage" included with this form. *By checking "Waive Coverage" you confirm that you waive coverage and have read and understand the "Waiver of Insurance Coverage" information included. **Dependent's dentist if different than above.

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 enrollment card.