EMPLOYEE ELECTION FORM

BenefitMall

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

THIS IS NOT AN APPLICATION FOR INSURANCE

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

Last Name	**First Name**	**M.I.**	**Employer**
Street Address			**Social Security Number**
City	**State**	**Zip**	**Gender** ☐ **Male** ☐ **Female** / **Date of Birth**
Home Telephone # ( )	**Business Telephone #** ( )	**Marital Status** ☐ **S** ☐ **M** ☐ **D** ☐ **W** / **Date of Marriage**	**Date Full-Time Employment Started:**
Are you actively working for the employer listed above (as defined in your insurance contract)? ☐ **Yes** ☐ **No** ☐ **Full-time** ☐ **Part-time**			**Hours Worked/Week**
Occupation	**Employee Class**		**Annual Salary**

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) **Relationship**

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

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.

CareFirst HMO

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

Waiver of Insurance Coverage

Medical- Notice of Special Enrollment Period

If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependent(s) in this plan in the future, provided that you request enrollment within 30 days of the termination date of your prior coverage. If you decline enrollment for yourself or your dependent(s) because of other health insurance coverage, you must complete the section titled ***"Other Health Insurance"*** on the Election Form to preserve your future enrollment rights.

If you decline coverage for yourself or a dependent(s) because of other health coverage and do not complete the ***"Other Health Insurance"*** section on the Election Form (or provide written proof from the other plan), or do not request enrollment in within 30 days after your (and/or) dependents' other coverage ends, you will not be eligible to enroll yourself or your dependent(s) during the enrollment period discussed above. You will then need to wait until the next open enrollment period (if applicable) to enroll in the plan's health coverage.

If you are currently declining coverage for you or your dependent(s), you can enroll yourself and/or your dependent(s) at a later date in accordance with the following special enrollment provisions:

- **You and/or your dependent(s) are no longer eligible under your spouse's coverage:**
  - because your spouse's employment or his/her group had been terminated;
  - you are divorced from your spouse; or
  - due to the death of your spouse.

- **You are no longer eligible under your parent's coverage.**

- **You and/or your dependent(s) have coverage through another group but later become ineligible for coverage through the group (including COBRA participants).**

- **Your group health plan may also allow employees who are already enrolled for coverage to add dependents upon marriage, birth, adoption, and placement for adoption.**

Please contact your Group Administrator for more detailed information on your group's Special Enrollment Provisions.

Non-Medical

If you are voluntarily declining the non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the availability of coverage, which is now being waived. Please be aware that late enrollment may cause an increase in cost and require a health questionnaire which may delay the effective date of your coverage.