

EMPLOYEE ELECTION FORM

BMLL Billing #	
Effective Date	
Team #	

THIS IS NOT AN APPLICATION FOR INSURANCE Carrier Group # (See Coverage Boxes)

	COBRA/Continu				crage	Employ	er wit	h 20 or more employees? [⊥ Yes ⊔ No
Last Name SURIKOV First Name Sergey				M.I. Emplo			yer Webworld		
C44 A 1.1	openhaver	Dr.						Social Security Number 230-51-7177	
City Potomac					ale 🗆 1] Female		Date of Birth 06/07/1957	
204 24D 8388	l — -	al Status M □ D □ W Date of Marriage 07/10/1995 defined in your insurance contract)?				Date Full-Time Employment Started: 09/03/2013			
Are you actively working for t ☐ Yes ☐ No ☐ Full-time	ted above (as d	defined in your insurance contract)?				Hours Worked/Week 40			
Occupation Software Eng	Em	Imployee Class				Annual Salary \$92,000			
MEDICAL PLAN (if offered) 1	(if offered) DENTAL PLAN (if offered)		VISION PLAN (if offered)				☐ LIFE AND AD&D (if offered)		
CarrierPlan Type	CarrierPlan Type		Carrier Carrier Group #				☐ Waive Coverage*		
Carrier Group #	Carrier Group #		Employee Only				\square v	OL LIFE \$	
☐ Employee Only	☐ Employee Only		Employee Chry Employee & Spouse					SPOUSE \$	
☐ Employee & Spouse	☐ Employee &	k Spouse	Employee & Spouse Employee / Child(ren)					DEP. CHILD \$	
☐ Employee / Child(ren)	☐ Employee /	Child(ren)	☐ Family				Carrie	er	
☐ Family	☐ Family		☐ Waive Co	erage*					
☐ Over 65 ☐ Retired ☐ Working	☑ Waive Cov	erage*				**	Пеп	TD (if offered)	vorago*
☐ Medicare or Complimentary to	Provider #		☐ LTD (if offered) ☐ Waive Coverage* ☐ VOL. LTD ☐ Waive Coverage*					OL. STD	
Medicare (CareFirst-Individual	Name Family Dentist*	**	U VOL. LTI		aive Cov	erage*	Plan #	ŧ	8
only; and benefit coverage only. Not eligible for HSA)	Name		Carrier				Benef	1t \$	/ WK.
☑ Waive Coverage*	Office #		Benefit \$			/Mo.	Carrier		
Life Insurance Beneficiary (if	coverage offered)					Re	elations	hip	
		Social Secu	rity Birt	h Sex	Stu-	Dis-	Fo	or HMO and POS Plans:	Existing
Last, Full First,	M.I.	Number	Dat	e	dent	abled		ary Care &OBGyn Carrier	Patient
					(Y/N)	(Y/N)	Assi	gned Provider # and name	(Y/N)
Emp					(Y/N)	(Y/N)	Assi	gned Provider # and name	(Y/N)
Emp Sp						` /	Assi	gned Provider # and name	(Y/N)
•						` /	Assi	gned Provider # and name	(Y/N)
Sp						` /	Assi	gned Provider # and name	(Y/N)
Sp Chd						` /	Assi	gned Provider # and name	(Y/N)
Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC	e <u>OR</u> if you are e "health" covera CBS 78937129	te: You must cocurrently cove age with another 48 Will this o	omplete this sered under Mer insurer? □No coverage be co	ection if wedicare. Yes Antinued?	aiving o	N N r enrolling ffective I No If	ng in n Oate:	nedical coverage and your 01/01/2013 erm. Date:	
Chd Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC Are you covered by Medicare? It is your spouse or dependent(s) or the coverage of	e <u>OR</u> if you are e "health" covera CBS 78937129 No \(\text{\text{T}}\) Yes Eff covered by Medi	te: You must or currently coverage with another 48 Will this cective Date (Parcare? No D	omplete this secred under Merinsurer? □No coverage be cort A) _/_/_ Yes Effective I	ection if we dicare. Yes Intinued? Seffective I late (Part A	aiving o f Yes: E Yes C Date (Par	r enrolling ffective I I No If t B) _/_	ng in n Date: 'No: Te _/_ M tive Da	nedical coverage and your 01/01/2013 erm. Date: fedicare # ate (Part B) _/_/_	
Chd Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC Are you covered by Medicare? It is your spouse or dependent(s) on Name of spouse or dependent(s)	e <u>OR</u> if you are e "health" covera CBS 78937129 Mo □ Yes Eff covered by Medi covered (if app	te: You must cocurrently coverage with another 48 Will this concern? No You Vilicable):	omplete this secred under Merinsurer? □Nocoverage be cort A)// Yes Effective I	ection if we dicare. Yes partinued? Sometimed Part A	aiving o f Yes: E Yes C Date (Par A)/	r enrolling ffective I I No If t B) _/_ /_ Effective I I Effective I I No I I I I I I I I I I I I I I I I	ng in n Date: 'No: Te _/_ M tive Da	nedical coverage and your 01/01/2013 erm. Date: fedicare # te (Part B)/_/_ Medicare #	
Chd Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC Are you covered by Medicare? It is your spouse or dependent(s) or the coverage of	e <u>OR</u> if you are e "health" covera CBS 78937129 Mo Yes Efficovered by Medi covered (if app y that group indual Coverage [te: You must or currently coverage with another 48 Will this cective Date (Parcare? No Silicable):	omplete this secret under More insurer? □No coverage be count A) _/_/_Yes Effective Inge has been of erage □ COF	ection if we dicare. Yes Matinued? State (Part August 1987) Greed to make the state of the sta	aiving o f Yes: E Yes C Date (Par A) ne and I edicare a	r enrolling ffective I I No If t B) _/_ /_ Effective I I S primary	ng in n Date: ENo: Te _/_ M tive Da	nedical coverage and your 01/01/2013 erm. Date: Medicare # te (Part B)/_/_ Medicare # te coverage due to: TEFRA □ No Coverage	
Chd Chd Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC Are you covered by Medicare? It is your spouse or dependent(s) on Name of spouse or dependent(s) *Waiver of Coverage: I certification I certification I hereby the condition of the coverage is individed the coverage in	e OR if you are a "health" coverace "health" coverace S 78937129 No Yes Efficovered by Media covered (if apply that group included Coverage I certify that I am a fraudulent clair	te: You must coverage with another 48 Will this coverage? No Silicable: Surance covera Military Coverage management with the spouse, pare to management with the spouse of	omplete this secret under More insurer? □No coverage be count A)// Yes Effective Inge has been of erage □ COF ent or legal guar of a loss or be	ection if we dicare. Yes Matinued? State (Part And Its Material Material of the profit or when the fit or who did not be seen to be	aiving o f Yes: E Yes C Date (Par A) ne and I edicare a e depend to knowing of the second of the seco	r enrolling ffective II INO Iffective II INO Iffect II INO Iffect II INO II	ng in n Date: M tive Da to waiv under own ab	nedical coverage and your 01/01/2013 erm. Date: fledicare # te (Part B)/_/_ Medicare # re coverage due to: TEFRA □ No Coverage rove. Any person who know	ringly
Chd Chd Chd Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC Are you covered by Medicare? It is your spouse or dependent(s) waiver of Coverage: I certife Spousal Coverage I ndivide CERTIFICATION: I hereby cand willfully presents a false or application for insurance is guident.	e <u>OR</u> if you are e "health" covera CBS 78937129 Mo Yes Eff- tovered by Medi covered (if app y that group institual Coverage I tertify that I am a fraudulent clai	te: You must or currently coverage with another 48 Will this dective Date (Parcare? No) Surance covera Military Covera Military Covera m for payment and may be subjective surance coverage for payment and may be subjective surance coverage.	omplete this secret under Mer insurer? □No coverage be count A)// Yes Effective Inge has been of the coverage □ COI ent or legal guate of a loss or be sect to fines and	ection if wedicare. Yes Matinued? State (Part Andrews Mark) Brand Mark Mark Mark Mark Mark Mark Mark Mark	aiving o If Yes: E The test of Yes	r enrolling ffective II INO Iffective II INO Iffect INO Iffect INO Iffect INO Iffect INO Includes Included Included Includes Included Included Includes Included Includes Included Includes Included Includes Included Includes Includes Includes Includes Included Includes Incl	ng in n Date: Mo: Te _/ M tive Da to waiv / under own ab d willfu	nedical coverage and your 01/01/2013 erm. Date: Medicare # Medicare # e coverage due to: TEFRA	ringly
Chd Chd Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC Are you covered by Medicare? It is your spouse or dependent(s) waiver of Coverage: I certife Spousal Coverage I ndivide CERTIFICATION: I hereby cand willfully presents a false or application for insurance is guidented. Voluntary benefits in	e OR if you are a "health" coverage S 78937129 No Yes Efficovered by Media covered (if apply that group institual Coverage I certify that I am a fraudulent claim that yof a crime and that yof a crime and the subject the subject to	te: You must coverage with another 48 Will this coverage? No Silicable: Surance covera Military Coverage of Military Coverage of the spouse, pare in for payment and may be subject of pre-existing coverage of the spouse of the	omplete this secret under Mer insurer? □No coverage be count A)// Yes Effective I ge has been of erage □ COI ent or legal guarent of a loss or be exect to fines and condition exclusions.	ection if we dicare. Yes Matinued? State (Part And Indian of the proof of the proo	aiving o If Yes: E The yes of Yes o	r enrolling ffective II No If the By Effective II with the sprimary lent(s) should be an increased and the sprimary lent(s) should be a sprimary lent(s) sho	ng in n Date:	nedical coverage and your 01/01/2013 erm. Date: Idedicare # Ite (Part B)/_/ Medicare # TEFRA □ No Coverage FOOVE. Any person who know Ily presents false information y for more information).	ringly on in an
Chd Chd Chd Chd Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC Are you covered by Medicare? It is your spouse or dependent(s) waiver of Coverage: I certife Spousal Coverage □ Individe CERTIFICATION: I hereby and willfully presents a false or application for insurance is guident of the control of the	e OR if you are a "health" coverage S 78937129 No Yes Efficovered by Media covered (if apply that group instant Coverage I certify that I am a fraudulent claim that yof a crime and the subject the any necessary	te: You must or currently coverage with another 48 Will this dective Date (Parcare? No) Surance covera Military Covera Military Covera for payment and may be subject to pre-existing of payroll deduction.	omplete this secret under Mer insurer? □No coverage be counted to the coverage of the coverage	ection if we dicare. Yes Intinued? State (Part Andrews of the property of the	aiving o If Yes: E The transport of Yes: E	r enrolling ffective II No If the By Effective II with the sprimary lent(s) should be a first on. The toyour billing to your billing to	ng in n Date:	nedical coverage and your 01/01/2013 erm. Date: Idedicare # Ite (Part B)/_/ Medicare # TEFRA □ No Coverage FOOVE. Any person who know Ily presents false information y for more information).	ringly on in an
Chd Chd Chd Chd Chd Chd Chd Chd	e OR if you are the 'health' covera SS 78937129 No Yes Efficovered by Medi to covered (if app y that group indual Coverage I the certify that I am a fraudulent claim if yo a crime an ay be subject the any necessary y current month	te: You must co currently coverage with another 48 Will this coverage with another eactive Date (Par care? No D Y licable):	omplete this sered under Mer insurer? □No coverage be counted to the coverage of a loss or be coverage □ COF and a loss or be cet to fines and condition exchanges and also do for intermed	rection if we dicare. Make yes and the properties of the properti	aiving o If Yes: E The and I I edicare a e dependent in prease refe any disal lity incorr	r enrolling ffective I I No If the By Effective I I no in the sprimary lent(s) should be an interest on the sprimary and the sprimary lent(s) should be a sprimary and the sprimary lent(s) should be a spr	ng in n Date: 'No: Te _/ No tive Da to waiv / under own ab d willfu r policy rerage i	nedical coverage and your O1/01/2013 erm. Date: Medicare # Medicare # TEFRA No Coverage over Any person who know lly presents false information of for more information). In force and applied for, with	ringly on in an
Chd Chd Chd Chd Chd Chd OTHER HEALTH INSURAN company offers Dual Coverage Do you or your dependents have Other Carrier name/policy #_BC Are you covered by Medicare? It is your spouse or dependent(s) waiver of Coverage: I certife Spousal Coverage □ Individe CERTIFICATION: I hereby and willfully presents a false or application for insurance is guident of the control of the	e OR if you are a "health" coverage "S 78937129 No Yes Efficovered by Media covered (if apply that group institual Coverage I certify that I am a fraudulent claim ity of a crime and the subject the any necessary yourrent month	te: You must or currently coverage with another 48 Will this dective Date (Parcare? No) Surance covera Military Coverage Military Coverage for payment and may be subject to pre-existing or payroll deduction of the payrol	omplete this secret under Mer insurer? □No coverage be count A)// Yes Effective Inge has been of erage □ COI ent or legal guate of a loss or be ext to fines and condition exclusions and also do for intermed	ection if we dicare. Yes Intinued? State (Part A dian of the dian of the disability of the confinement of t	aiving o If Yes: E The Yes of Yes o	r enrolling ffective I I No If t B) _/_ /_ Effective I I S primary lent(s) should be in the sprimary lent(s)	ng in n Date:	nedical coverage and your O1/01/2013 erm. Date: Medicare # Medicare # TEFRA No Coverage over Any person who know lly presents false information of for more information). In force and applied for, with	ringly on in an

¹If 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.

Fax: (410) 512-3984

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:
 - o because your spouse's employment or his/her group had been terminated;
 - o you are divorced from your spouse; or
 - o 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.