

SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM

THIS IS NOT
AN APPLICATION
FOR INSURANCE



1 EMPLOYER INFORMATION: To be completed by the employer.

Employer/Group Administrator _____	Group Numbers: BlueChoice _____ Dental _____
Effective Date Requested ___/___/___	Vision _____ Other _____

Check all that apply
 Employment Status: Active Full Time Part Time Retired

2 TYPE OF REQUEST

<input type="checkbox"/> New Subscriber <input type="checkbox"/> Coverage Change <input type="checkbox"/> Add Dependents <input type="checkbox"/> Delete Dependents <input type="checkbox"/> Any information change (name or address change)	Are you enrolling eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
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3 SUBSCRIBER INFORMATION

Social Security Number ____-____-____	Subscriber Last Name	First Name	Middle Initial
Date of Birth ___/___/___	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire: ___/___/___	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married/Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed Effective Date of Status ___/___/___
Street Address	Apt.	City	County State
Country	Zip	Home Phone () _____ - _____	Work Phone () _____ - _____

4 COVERAGE LEVEL

Coverage Level: <input type="checkbox"/> Individual <input type="checkbox"/> Individual and Adult <input type="checkbox"/> Individual and Child(ren) <input type="checkbox"/> Family	Coverage Selected: Check only those options that your employer has elected to offer. <input type="checkbox"/> BlueChoice <input type="checkbox"/> BlueChoice <i>Open Access</i> <input type="checkbox"/> BlueChoice Opt-Out <i>Open Access</i> <input type="checkbox"/> BlueChoice Opt-Out <i>Plus</i> <input type="checkbox"/> BlueChoice Opt-Out <i>Plus Open Access</i> <input type="checkbox"/> BlueVision <i>Plus</i> <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental HMO Opt Out <input type="checkbox"/> Traditional Dental <input type="checkbox"/> Preferred Dental
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5 SUBSCRIBER & DEPENDENT INFORMATION: Please list all persons to be covered.

List the primary care physician for each person and indicate if that person is currently a patient of that physician.

Last	First	MI	Relationship	Sex	Date of Birth	Social Security Number	Existing Patient	Disabled *	Student **	Primary Care Physician	PCP ID Number
			Subscriber				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Spouse/ Partner				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

***If yes, disabled, please attach disability certification form and supporting documentation.**

****If full time student, please attach student certification form.**

6 MEDICARE INFORMATION: To be completed if applicable.

Are You Eligible for Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: _____ - _____ - _____	Hosp. Eff. Date (Part A) ____/____/____	Med. Eff. Date (Part B) ____/____/____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				
Spouse/Partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: _____ - _____ - _____	Hosp. Eff. Date (Part A) ____/____/____	Med. Eff. Date (Part B) ____/____/____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				
Child/Dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: _____ - _____ - _____	Hosp. Eff. Date (Part A) ____/____/____	Med. Eff. Date (Part B) ____/____/____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				

7 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 ____/____/____
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Name and Address of Insurance Company _____

Policy Number	Termination Date ____/____/____	Policy Covers <input type="checkbox"/> Policyholder Only <input type="checkbox"/> Two Person <input type="checkbox"/> Family	Effective Date of Policy ____/____/____
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Services Covered: Hospital Services Physician Services Major Medical Drug Program
 Dental Services Eye/Vision Care Services HMO

Does this policy cover you? Yes No Your Spouse/Partner? 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 enroll, on behalf of myself and each dependent listed above, for the health coverage indicated. If this Form is accepted, coverage will be provided according to terms and conditions of the health care contract between CareFirst BlueCross BlueShield and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution.

I have carefully read this Form and agree to its terms. The recorded answers on this Form 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.

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 Form.

Subscriber's Signature _____	Date ____/____/____	Dependent's Signature _____	Date ____/____/____
Authorization Signature _____	Date ____/____/____		