

# SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM

THIS IS NOT  
AN APPLICATION  
FOR INSURANCE

**CareFirst**   
**BlueCross BlueShield**  
840 First Street, NE  
Washington, DC 20065

## 1 EMPLOYER INFORMATION: To be completed by the employer.

Employer/Group Administrator	Group Number:
Effective Date Requested ___/___/___	Medical: _____ Dental: _____
Medical Option: _____ Vision: _____	

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

## 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
---	--

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

**COVERAGE LEVEL – Please confirm with your employer the details of the benefit options and coverage levels 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

**Coverage Level for Medical Option:**  
 Individual     Individual and Adult     Individual and Child(ren)     Family

**Coverage Level for Dental Option (if applicable and your employer has elected to offer):**  
 Individual     Individual and Adult     Individual and Child(ren)     Family

**Coverage Level for BlueVision Plus Option (if applicable and your employer has elected to offer):**  
 Individual     Individual and Adult     Individual and Child(ren)     Family

### SUBSCRIBER INFORMATION

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
			<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	Subscriber			
			<input type="checkbox"/> Medical <input type="checkbox"/> Traditional Dental <input type="checkbox"/> Preferred Dental <input type="checkbox"/> BlueVision Plus				

### 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
			<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete				
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus				
			<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete				
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus				
			<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete				
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> 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.

**5 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				

**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/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.**

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