

ENROLLMENT APPLICATION

Benefits Administered by CareFirst Administrators

New
 Change

Employee - If you are applying for coverage with your employer's benefit plan, please complete Parts 2 - 6. If you do not desire coverage under your employer's plan, please complete Parts 2, 3 (as applicable) and 7. **Please print clearly.** Incomplete and/or illegible forms will be returned.

Part 1 - Employment Information (TO BE COMPLETED BY THE EMPLOYER)

a) Company Name: _____ b) Subgroup: _____
c) Effective Date: _____ d) Employee Date of Hire _____
e) Salary: _____

Part 2 - Employee Information

a) Social Security Number: _____
b) Name: Last _____ c) First: _____ d) Middle: _____
e) Street: _____ f) Gender: Male Female
g) City: _____ h) Date of Birth: _____
i) State: _____ j) Zip: _____ k) Status: Single Married Divorced Widowed

Part 3 - Coverage Information

a) Medical/[Prescription]Plan [Option]
 [Option]
 [Option]

b) Dental Plan [Option]
 [Option]
 [Option]

c) Vision Plan [Option]
 [Option]
 [Option]

d) Coverage Level
 Employee Only
 Employee + Child[(ren)]
 Employee + Spouse
 Employee + Family

Part 4 - Dependent Information - Complete below unless you elected Single coverage in Part 3 above.

Last Name	First Name	Middle Name	Date of Birth	Relationship	Gender	Social Security Number
a) _____	_____	_____	b) _____	c) Spouse	d) _____	e) _____
f) _____	_____	_____	g) _____	h) _____	i) _____	j) _____
k) _____	_____	_____	l) _____	m) _____	n) _____	o) _____
p) _____	_____	_____	q) _____	r) _____	s) _____	t) _____
u) _____	_____	_____	v) _____	w) _____	x) _____	y) _____

Part 5 - Other Coverage Information

a) Are you or any member of your family covered by any other group insurance, HMO Plan, or Federal program including Medicare?
Medical Yes No; **Dental** Yes No; **Vision** Yes No; **Prescription** Yes No (Complete below for Medicare)

b) If yes, Name of Carrier: _____ c) Policy ID#: _____
d) Address: _____
e) Effective Date: _____
f) Policyholder Name: _____
g) Are family members covered? Yes No If yes, which ones? Employee Spouse Children
If yes, is this Plan Primary (P) or Secondary (S) for: P S Employee P S Spouse P S Children

Medicare Part A Yes No; **Medicare Part B** Yes No; **Medicare Part D** Yes No

b) If yes, Name of Carrier: _____ c) Health Insurance Claim# (HIC#): _____
d) Address: _____
e) Effective Date Part A: _____ Effective Date Part B: _____ Effective Date Part D: _____
f) Policyholder Name: _____
g) Are family members covered? Yes No If yes, which ones? Employee Spouse Children
If yes, is this Plan Primary (P) or Secondary (S) for: P S Employee P S Spouse P S Children

Part 6 - Request for Group Insurance

I have attached a copy of my certificate(s) of creditable coverage that may reduce my pre-existing waiting period Yes No
I hereby apply for insurance to which I am entitled issued by the Group. I meet the eligibility requirements of this plan and authorize the deduction from my earnings of any contribution I may be required to make toward the cost of the plan.

Employee's Signature: _____ Date: _____

Part 7 - Waiver for Group Health Insurance

Check the appropriate box below and then sign and date at the bottom.

I am declining coverage under this Plan as I currently have coverage under another group health plan. Yes No

I hereby certify that I have been offered an opportunity to become covered under the benefit plan sponsored by my employer and I have, on behalf of myself, and/or my spouse, and/or children, decided NOT to take advantage of this offer.

Employee's Signature: _____ Date: _____

Employer's Signature/Verification: _____ Date: _____

Form 11/10/05

CareFirst Administrators, an independent corporation operating under a license from the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.