

## SMALL EMPLOYER GROUP OPTIONS ENROLLMENT FORM: BlueChoice HRA/HSA

### 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 Applies to all benefits checked below (Dental - Parallel Enrollment only)

<b>Coverage Level:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Individual and Adult <input type="checkbox"/> Individual and Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Coverage Complementary to Medicare (Individual Only and benefit coverage only; not eligible for HSA.)	<input type="checkbox"/> BlueChoice HMO HSA <i>Open Access</i> (BlueFund) <input type="checkbox"/> BlueChoice Opt-Out <i>Plus HSA Open Access</i> (BlueFund) <input type="checkbox"/> BlueChoice HMO HRA <i>Open Access</i> (BlueFund) <input type="checkbox"/> BlueChoice Opt-Out <i>Plus HRA Open Access</i> (BlueFund)	<input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental HMO Opt Out
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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 BlueChoice, Inc. and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution.

**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.**

**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 the processing of your Form or claims payment.**

**If you have any questions concerning the benefits and services that are provided by or excluded under the coverage for which you are applying, please contact a membership services representative before signing this Form.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

