



Benefit Administrators Since 1989

600 Washington Avenue, Suite 104, Towson, MD 21204
410.494.0010 800.741.4BDG Fax 410.494.0456
www.bdgmd.com

Maryland MSGR (2-50) New Case Checklist
Blue Choice Medical, Blue Preferred Medical,
Regional Dental, and Vision

1. **Signed Rate Quote** (Paper rates are unacceptable.) All of the pages to the signed rate proposal are required when the group is submitted, including the disclosure. Core plans require a rate quote if selected.
2. **Tax Documentation** (Required for all CareFirst Submissions)
Please refer to Tax Documentation summary from Page 27 of the 2009 CareFirst broker manual.
Automated Payroll registers are acceptable if the payroll company's name is printed on it.
(eg., ADP, Paychex, Safeguard, etc.) NOTE: THIS CANNOT BE A PAYROLL SPREADSHEET BY THE GROUP.
3. **Group Application for Blue Choice** GRAPP-PPO(MD/CF/MSGR/GRP APP (R. 4/09))
Group signature, Broker signature and tax identification number must be on the group application.
4. **Completed Employee Election Forms** (Revised 1/08)
Please have each employee complete questions 1-6, sign, date, and select the benefit election and coverage level for each product. PCP name and number is required for all HMOs, including Opt Outs.
5. **Group Application for Blue Preferred Medical, Regional Dental, or Vision**
(MD/CF/MSGR/GRP APP (R. 4/09))
Broker Signature and Tax identification number must be on the group application.
6. **Waiver of Enrollment Form** (CUT6529-1S (6/04)) Full time employees declining coverage.
7. **Student Certification for Overage Dependents** (CUT5798-1S 1/02)
Extended Dependent Coverage Request.
8. **COBRA Selection Form** (CUT5870-1S 3/02) Must be accompanied by completed Enrollment Election Form or Selection Form for Those Groups Not Eligible for COBRA (CUT5862-1S (3/02)) MD Continuation)
9. **Check payable to: Benefit Design Group LLC**
*1st of the month effective date include 1 month's premium. *15th of the month effective date include 1½ month's premium.
10. **Authorization Agreement for Preauthorized Payments Form** (4/18/03)
For groups with 5 or less enrolled employees. First month's premium must be paid with group submission.
11. **Indicate Prior Carrier (If Applicable)** _____

Indicates documentation required for all cases

*Please submit completed paperwork to Benefit Design Group at least one day prior to the deadline. Posted on our website, www.benefitdesigngroup.com are the specific deadline dates. Thank you.

Tax Documentation

The following information was either provided by State legislation (as in the case of a self-employed individual), or by the Maryland Office of Unemployment Insurance to determine which tax documents are available to verify eligibility of an employer group and its employees:

TYPE OF BUSINESS	DLLR/OUI 15/16 REQUIRED IF EMPLOYEES ARE	DLLR/OUI 15/16 NOT REQUIRED IF EMPLOYEES ARE	IF NO DLLR/OUI 15/16 REQUIRED, SUBMIT INSTEAD
Self-Employed Individuals Self-Employed “Licensed Professionals” such as <i>Attorneys, physicians (LLP “Limited Liability Partnership” excluded)</i>			Signed Form 1040 or 1040EZ and any one of the following: Schedule C, C-EZ, F, SE, Form 1120, 1120-S or Form 1065 with K-1, Form 7004, and Form 4868. Articles of (Professional) Incorporation and “Letter of Good Standing” from licensing group
Effective 10/1/05 self-employed are no longer considered “small employer groups.” No open enrollment periods will be offered.			
Corporation <i>(HB 857, HB 988 or HB 1359: 2+ eligibles)</i>			Form 1120, Form 1120-S or Articles of Incorporation showing owners of business
<i>Note: In most cases, corporations will have a formal Wage & Tax (DLLR/OUI 15/16)**</i>			
Sole Proprietorship <i>(HB 857, HB 988 or HB 1359: 2+ eligibles)</i>	Owner’s children (over age 21) Other employees	Owner Spouse Owner’s children (under age 21) Owner’s parents	Signed Schedule C/ F Showing <i>at least</i> Husband and wife as Owners**
Partnership <i>(HB 857, HB 988 or HB 1359: 2+ eligibles)</i>	Spouse Owner’s children Other employees	Partners	Form 1065 and signed K-1 forms for each Partner**
Non-Profit Organization <i>(1 sole eligible employee working 20 hrs/wk)</i>		Any employee(s)	IRS Form 501(c)(3) a.k.a. “Letter of Determination” w/ notarized letter on company letter-head, listing employees, hours per week/eligibility status*

Note that a current Wage and Tax Statement (DLLR/OUI 15/16) is required on all accounts including those migrating between CareFirst companies. Stock certificates are not accepted as proof of ownership.

*In lieu of Form 501 C 3, will accept the Charter Documents of the organization along with an Affidavit of a CPA certifying the status of the organization pursuant to IRC 501 C 3.

**If the owners are the only employees, in addition to the tax documents they must also submit a notarized letter on company letterhead listing the name of each, the number of hours per week each works, and their eligibility status.

CareFirst BlueChoice, Inc.

840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

GROUP CONTRACT APPLICATION
Maryland Small Group Business

<p><input type="checkbox"/> APPLICATION FOR CONTRACT (New Group)</p> <p>Please complete the entire application.</p>	<p><input type="checkbox"/> APPLICATION FOR AMENDMENT (Existing Group)</p> <p>Fill in Name of Organization and Group Number. Complete only those areas in which information is changing.</p> <p>Group Number _____</p>
---	--

Please sign and return this application to your Sales Representative.
No retroactive effective dates for new groups or amendments will be permitted.

Name of Organization: _____
(Group) *(Name as it appears above will be used in your Group Contract)*

Physical Location: _____
Street

_____ *City* _____ *State* _____ *Zip*
(Group location must be within the State of Maryland)

Mailing Address: _____
(if other than above) *Street*

_____ *City* _____ *State* _____ *Zip*

Chief Executive Officer: _____
Name Title Telephone No.

Group Administrator: _____
(Person to Contact) Name Title Telephone No.

Nature of Business: _____
(Please Specify)

Type of Organization Partnership Independent Contractor Other _____

Federal Tax Identification Number: _____

Eligibility and Enrollment

Group Eligibility Requirements -- To be eligible for coverage and maintain its eligibility, the Group must meet all requirements for a Small Employer as provided under the Maryland Small Employer Insurance Business Reform Law. Generally, you must be a Maryland employer that employed at least 2 but not more than 50 Eligible Employees on 50% of the work days during the preceding calendar quarter; the majority of whom were employed within the State of Maryland; and is a person actively engaged in a business or is the governing body of: a charter home-rule county established under Article XI-A of the Maryland Constitution; a code home-rule county established under Article XI-F of the Maryland Constitution; a commission county established or operating under Article 25 of the Code; or a municipal corporation established or operating under Article XI-E of the Maryland Constitution; or an entity that leases employees from a professional employer organization, coemployer, or other organization engaged in employee leasing. "Small Employer" also means non-profit organizations that are exempt from taxation under §501(c)(3), (4), or (6), of the Internal Revenue Code and employ at least one but not more than 50 Eligible Employees. In determining if the Group employs the requisite number of Eligible Employees, Part-Time Employees will not be included. However, an employer is considered to continue to be a Small Employer if the employer met the requirements for a Small Employer and subsequently eliminated all but one Eligible Employee.

If the Small Employer previously met the definition of a "Small Employer" and ceases being a Small Employer based solely on the new definition, may continue to renew previously purchased coverage. The Group Sales Representative or broker can help you obtain additional detailed information about the requirements of the Maryland Small Employer Insurance Business Reform law.

Eligible Employees -- Eligible Employee means an employee who works on a full-time basis and has a normal workweek of 30 or more hours. Eligible Employee includes:

- A. A partner of a partnership and an independent contractor who is included as an employee under a health benefit plan under the Maryland Small Employer Insurance Business Reform Law; and
- B. A sole employee of a nonprofit organization, which has been determined by the Internal Revenue Service to be exempt from taxation under section 501(c)(3), (4), or (6) of the Internal Revenue Code, who has a normal workweek of 20 or more hours and is not covered under a public or private health insurance plan or other health benefit arrangement.

The Eligible Employee must work or reside in the Service Area at the time of enrollment. Eligible Employee does not include an individual who works on a temporary or substitute basis or for less than 30 hours in a normal workweek, except for an individual described in item B.

Additional Eligibility Options -- The Group may elect to cover Part-Time Employees and/or employees covered under another public or private plan of health insurance or other health benefit arrangement.

- Check here if you wish to cover **Part-Time Employees**.
"Part-Time Employee" means an employee who has a normal workweek of at least 17½ hours a week, but less than 30 hours a week and has been continuously employed for at least four consecutive months.
- Check here if you wish to cover **Employees With Other Coverage**
"Other Coverage" means another public or private plan of health insurance or other health benefit arrangement including Medicare, Medicaid or Champus, that provides benefits similar to or exceeding the benefits provided under the Group Contract.

Effective Date -- Coverage for a new Eligible Employee will be effective on the first day of the month following the date of hire unless otherwise specified below:

- on the date of hire
- on the first day of the month following 30 days of employment
- on the first day of the month following 60 days of employment
- on the first day of the month following 90 days of employment
- other: _____

Minimum Enrollment Requirements -- The Group must enroll and maintain enrollment of at least 75% of all Eligible Employees. To determine enrollment, the Plan considers all Eligible Employees, except those who have group spousal coverage under a public or private plan of health insurance, or a health benefit arrangement through another employer that provides benefits similar to or exceeding the benefits under the Group Contract, including Medicare, Medicaid, and CHAMPUS, and Part-Time employees. If the Group offers another health benefits program through the Plan and/or through another CareFirst affiliated or related entity, the total Group enrollment in all such plans will be combined to determine enrollment.

Enrollment Certification -- The Plan reserves the right to inspect the records of the Group in order to verify the eligibility of employees and their Dependents. In addition, the Group may be required to complete and return to the Plan an eligibility audit and/or census report annually.

Point-of-Service Option

The following provision applies only if the Group offers CareFirst BlueChoice to its employees as the sole health benefits option:

Under Maryland Law, your Group Members may purchase a point-of-service option as an additional benefit. A point-of-service option allows your Group Members to obtain health care services from physicians and other providers outside the HMO network under certain circumstances that are described in Attachment A.

The Group has the choice to either pay for this point-of-service option, pay a percentage of the cost of this option, or require your Group Members to pay for the entire cost of this option. The cost of the point-of-service option described in Attachment A is described in your proposal. List below the Group Members who have chosen this point-of-service option.

I have read and understand this disclosure statement and the attachments and have provided notice of the availability of this additional benefit to the eligible Group Members.

Listing of Employees Selecting the Point-of Service Option

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Terms

Rates and Coverage -- Please attach the appropriate rate and benefit schedule for the coverage selected. This application cannot be processed without the schedule. If the actual enrollment varies from that used in the original rating such that the Group is not eligible for Maryland Small Employer Insurance Business Reform Law coverage, the Group will be required to apply for other coverage by completing a new application and will be charged different rates.

Group Statements -- The Group agrees that in submitting this application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The Group is not the agent or representative of the Plan for any purpose of this application or any group agreement issued pursuant to this application.

The Group agrees to receive on behalf of its Subscribers and their Dependents and COBRA participants, if applicable, the Evidence of Coverage, the identification cards, and all relevant notices furnished by the Plan and to forward such materials to these individuals at their last known address.

Following approval of this application, the Plan will issue a Group Contract if the Group is a new Group. If the Group is an existing Group, the Plan will either issue a new Group Contract (if there are substantial changes) or amend your current Group Contract. The Plan can amend your Group Contract through acceptance and approval of this application or by issuing a new rider or endorsement to your Group Contract.

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.

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 application.

BY: _____
(Printed Name of Authorized Officer)

(Signature of Authorized Officer)

Title: _____

Date: _____

Amount Enclosed: \$ _____ (For new groups only)

Non-Binding Acceptance of Application, Subject To Final Approval By CareFirst BlueChoice, Inc.

BY: _____ Date _____
(Signature of Broker or Sales Representative)

Broker or Rep. Code ID # _____

CareFirst BlueChoice, Inc. Approval:

BY: _____ Date _____
Director, Account Implementation

Effective Date of Group Coverage _____

ATTACHMENT A
Description of Point-of-Service Options

A point-of-service option allows eligible Group Members to obtain health care services from physicians and other providers outside the HMO network under certain circumstances as described in the Evidence of Coverage.

BENEFIT DESIGN GROUP, LLC

600 Washington Avenue, Suite 104, Towson, Maryland 21204
 (410) 494-0010 or (800) 741-4234 FAX: (410) 494-0456
 www.benefitdesigngroup.com

For BDG Use:

Date Rec'd: _____
 Carrier: _____
 BDG: _____

EMPLOYEE ELECTION FORM (THIS IS NOT AN APPLICATION FOR INSURANCE)

New Enrollee Coverage Change Add/Delete Dependents Termination COBRA Direct Bill COBRA Waiver (Complete 1,3,5 & 6 Only)

Employer: _____ Customer #: _____ Phone #: _____ Requested Effective Date _____

1	Employee Name _____ Last First M.I.		Social Security # _____																																																													
	Address _____		Sex _____ Birth Date _____ M/F																																																													
	City _____ ST _____ Zip _____		Home Phone _____																																																													
	Full-Time Hire Date _____ Hours worked/wk _____		Marital Status Single _____ Married _____																																																													
	Are you actively at work on a full-time basis for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																															
2	TO BE COMPLETED ONLY IF APPLYING FOR LIFE/AD&D, STD OR LTD COVERAGE																																																															
	Occupation _____		Class _____ Annual Salary _____																																																													
	Beneficiary _____		Relationship _____																																																													
3	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:15%;">Soc. Sec. No.</th> <th style="width:10%;">Birth Date</th> <th style="width:5%;">M/F</th> <th style="width:20%;">Primary Care Physician or Med. Center Name</th> <th style="width:10%;">PCP or MC ID #</th> <th style="width:5%;">Existing Patient (Y/N)</th> <th style="width:5%;">Disabled (Y/N)</th> <th style="width:5%;">Student (Y/N)</th> </tr> </thead> <tbody> <tr> <td>Emp</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Sp</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Ch</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Ch</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Ch</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>											Soc. Sec. No.	Birth Date	M/F	Primary Care Physician or Med. Center Name	PCP or MC ID #	Existing Patient (Y/N)	Disabled (Y/N)	Student (Y/N)	Emp									Sp									Ch									Ch									Ch								
	Soc. Sec. No.	Birth Date	M/F	Primary Care Physician or Med. Center Name	PCP or MC ID #	Existing Patient (Y/N)	Disabled (Y/N)	Student (Y/N)																																																								
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	PARTICIPATING DENTIST/PROVIDER CODE (if required): NAME/CODE: _____																																																															
4	Medicare: Y _____ N _____ Date (Part A) ____/____/____ Date (Part B) ____/____/____ Medicare # _____ TEFRA: Check here if all of the following apply to you. 1) Age 65 or over. 2) Eligible for Medicare. 3) Actively employed. 4) Continuing group coverage as primary coverage. 5) Your employer meets TEFRA requirements. _____ Self _____ Spouse																																																															
5	BENEFIT ELECTIONS:																																																															
	Medical Plan (Gp# _____) Carrier: _____ Plan: _____		Dental Plan (Gp# _____) Carrier: _____ Plan: _____		Vision Plan (Gp# _____) Carrier: _____ Plan: _____		<input type="checkbox"/> Life/AD&D <input type="checkbox"/> Dep. Life <input type="checkbox"/> None Have you used tobacco products within last 2 Yrs? Y N Carrier: _____ (Gp# _____) Benefit \$ _____ Sup. \$ _____																																																									
	<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child <input type="checkbox"/> Individual/children <input type="checkbox"/> Individual/adult <input type="checkbox"/> Family <input type="checkbox"/> Over 65 & Working <input type="checkbox"/> Over 65 & Retired <input type="checkbox"/> Waive Coverage		<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child <input type="checkbox"/> Individual/children <input type="checkbox"/> Individual/adult <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage		<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child <input type="checkbox"/> Individual/children <input type="checkbox"/> Individual/adult <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage		<input type="checkbox"/> STD <input type="checkbox"/> Vol. STD <input type="checkbox"/> None Carrier: _____ (Gp# _____) Benefit/week \$ _____ <input type="checkbox"/> LTD <input type="checkbox"/> Vol. STD <input type="checkbox"/> None Carrier: _____ (Gp# _____) Benefit/ month \$ _____																																																									
6	OTHER INSURANCE INFORMATION (Must Complete)																																																															
	Did you or your dependents have prior coverage with another insurer? <input type="checkbox"/> Yes/ Group coverage <input type="checkbox"/> Yes/Non-Group coverage <input type="checkbox"/> No																																																															
	Other Health Insurer Name/Policy # _____					Insurer/Carrier Address _____																																																										
	Will you or your dependents described on this form continue with another insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																															
	Who is covered? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> All					Effective Date: _____ Term Date: _____																																																										

CERTIFICATION: I hereby elect, on behalf of myself and each listed dependent for the coverage(s) indicated. If accepted, coverage(s) will be provided according to the terms and conditions of the benefit plan(s) between my employer or (if Applicable) myself and I agree to be bound by the plans of which this form will become part. I also agree to pay current and future subscription charges for the coverage(s) provided if required by my employer. I have carefully read this Election 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.

EMPLOYEE SIGNATURE: √ _____ DATE: _____

EMPLOYER SIGNATURE/VERIFICATION: √ _____ DATE: _____

IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY OR EXCLUDED, PLEASE CONTACT A MEMBERSHIP SERVICES REPRESENTATIVE BEFORE SIGNING THIS EMPLOYEE ELECTION FORM.

Group Hospitalization and Medical Services, Inc.

doing business as

CareFirst BlueCross BlueShield (CareFirst)

840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

GROUP CONTRACT APPLICATION

Maryland Small Group Business

<input type="checkbox"/> APPLICATION FOR CONTRACT (New Group) Please complete the entire application.	<input type="checkbox"/> APPLICATION FOR AMENDMENT (Existing Group) Fill in Name of Organization and Group Number. Complete only those areas in which information is changing. Group Number _____
---	--

**Please sign and return this application to your Sales Representative.
No retroactive effective dates for new groups or amendments will be permitted.**

Name of Organization: _____
(Group) *(Name as it appears above will be used in your Group Contract)*

Physical Location: _____
Street

_____ *City State Zip*

Mailing Address: _____
(if other than above) *Street*

_____ *City State Zip*

Chief Executive Officer: _____
Name Title Telephone No.

Group Administrator: _____
(Person to Contact) *Name Title Telephone No.*

Nature of Business: _____
(Please Specify)

Type of Organization Partnership Independent Contractor Other _____

Federal Tax Identification Number: _____

Eligibility and Enrollment

Group Eligibility Requirements -- To be eligible for coverage and maintain its eligibility, the Group must meet all requirements for a Small Employer as provided under the Maryland Small Employer Insurance Business Reform Law. Generally, you must be a Maryland employer that employed at least 2 but not more than 50 Eligible Employees on 50% of the work days during the preceding calendar quarter; the majority of whom were employed within the State of Maryland; and is a person actively engaged in a business or is the governing body of: a charter home-rule county established under Article XI-A of the Maryland Constitution; a code home-rule county established under Article XI-F of the Maryland Constitution; a commission county established or operating under Article 25 of the Code; or a municipal corporation established or operating under Article XI-E of the Maryland Constitution; or an entity that leases employees from a professional employer organization, coemployer, or other organization engaged in employee leasing. "Small Employer" also means non-profit organizations that are exempt from taxation under §501(c)(3), (4), or (6), of the Internal Revenue Code and employ at least one but not more than 50 Eligible Employees. In determining if the Group employs the requisite number of Eligible Employees, Part-Time Employees will not be included. However, an employer is considered to continue to be a Small Employer if the employer met the requirements for a Small Employer and subsequently eliminated all but one Eligible Employee.

If the Small Employer previously met the definition of a "Small Employer" and ceases being a Small Employer based solely on the new definition, may continue to renew previously purchased coverage. The Group Sales Representative or broker can help you obtain additional detailed information about the requirements of the Maryland Small Employer Insurance Business Reform law.

Eligible Employees -- Eligible Employee means an employee who works on a full-time basis and has a normal workweek of 30 or more hours. Eligible Employee includes:

- A. A partner of a partnership and an independent contractor who is included as an employee under a health benefit plan under the Maryland Small Employer Insurance Business Reform Law; and
- B. A sole employee of a nonprofit organization, which has been determined by the Internal Revenue Service to be exempt from taxation under section 501(c)(3), (4), or (6) of the Internal Revenue Code, who has a normal workweek of 20 or more hours and is not covered under a public or private health insurance plan or other health benefit arrangement.

Eligible Employee does not include an individual who works on a temporary or substitute basis or for less than 30 hours in a normal workweek, except for an individual described in item B.

Additional Eligibility Options -- The Group may elect to cover Part-Time Employees and/or employees covered under another public or private plan of health insurance or other health benefit arrangement.

- Check here if you wish to cover **Part-Time Employees**
"Part-Time Employee" means an employee who has a normal workweek of at least 17-1/2 hours a week, but less than 30 hours a week and has been continuously employed for at least four consecutive months.
- Check here if you wish to cover **Employees With Other Coverage**
"Other Coverage" means another public or private plan of health insurance or other health benefit arrangement including Medicare, Medicaid or Champus, that provides benefits similar to or exceeding the benefits provided under the Group Contract.

Effective Date -- Coverage for new Eligible Employees will be effective on the first day of the month following the date of hire unless otherwise specified below:

- on the date of hire
- on the first day of the month following 30 days of employment
- on the first day of the month following 60 days of employment
- on the first day of the month following 90 days of employment
- other: _____

Minimum Enrollment Requirements – The Group must enroll and maintain enrollment of at least 75% of all Eligible Employees. To determine enrollment, CareFirst considers all Eligible Employees, except those who have group spousal coverage under a public or private plan of health insurance, or a health benefit arrangement through another employer that provides benefits similar to or exceeding the benefits under this Group Contract, including Medicare, Medicaid, and CHAMPUS, and Part-Time employees. If the Group offers another health benefits program through CareFirst and/or through CareFirst BlueChoice, Inc., and/or another CareFirst affiliated or related entity the total Group enrollment in all such plans will be combined to meet the minimum participation requirement.

The Group must enroll and maintain enrollment of at least 75% of all Eligible Employees for medical coverage and for each ancillary product purchased, if offered. The ancillary products are dental and vision] benefits. If at any time there are less than 75% enrolled in any of the medical or ancillary products, CareFirst reserves the right to rescind the proposal, revise the rates, terminate the product that does not meet the 75% requirement, or refuse to renew the product that does not meet the 75% requirement.

Enrollment Certification -- CareFirst reserves the right to inspect the records of the Group in order to verify the eligibility of employees and their Dependents. In addition, the Group may be required to complete and return to CareFirst an eligibility audit and/or census report annually.

Other Terms

Rates And Coverage -- Please attach the appropriate rate and benefit schedule for the coverage selected. This application cannot be processed without the schedule. If the actual enrollment varies from that used in the original rating such that the Group is not eligible for Maryland Small Business Insurance Reform Law coverage, the Group will be required to apply for other coverage by completing a new application and will be charged different rates.

Group Statements -- The Group agrees that in submitting this application, it is acting for and on behalf of itself and as the agent and representative of its employees and COBRA participants, if applicable. The Group is not the agent or representative of CareFirst for any purpose of this application or any Group Contract issued pursuant to this application.

The Group agrees to receive on behalf of its Subscribers and their Dependents and COBRA participants, if applicable, the Certificates of Coverage, the identification cards, and all relevant notices furnished by CareFirst and to forward such materials to these individuals at their last known address.

Following approval of this application, CareFirst will issue a Group Contract if you are a new Group. If you are an existing Group, CareFirst will either issue a new Group Contract (if there are substantial changes) or amend your current Group Contract. CareFirst can amend your Group Contract through acceptance and approval of this application or by issuing a new rider or endorsement to your Group Contract.

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.

BY: _____
(Printed Name of Authorized Officer)

(Signature of Authorized Officer)

Title: _____

Date: _____

Amount Enclosed: \$ _____ (For new groups only)

Non-Binding Acceptance of Application, Subject To Final Approval By CareFirst:



Waiver of Enrollment Form

Employee Name _____

Social Security Number _____

Group Name _____

Group Number _____

Employment date _____

I certify that the health protection plan of CareFirst BlueCross BlueShield/CareFirst BlueChoice has been explained to me and at this time I choose:

- Not to enroll or, FOR myself and my dependents, (if any)
- If enrolled, to cancel coverage my dependents only

The other coverage is (select one):

- Commercial Insurance Policy (employer sponsored only)
- Spouse's group health benefit plan
- CHAMPUS
- Medicare as primary under TEFRA
- COBRA

Note that coverage through an individual policy is not considered a valid reason for waiver.

Please check which benefits you and/or your dependents have with the other carrier.

- Medical
- Dental
- Vision

I understand that if I decide later to enroll myself and/or dependents, all such late enrollees will be subject to the special enrollment requirements, as detailed on the next page. I declare that the information I have furnished above, to the best of my information and belief, is true, correct and complete.

Signature of Employee _____

Date _____

CUT6529-1S (6/04)

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

You or your dependent(s) are not considered Late Enrollees when you or your dependent(s) are covered under your spouse's or parent's coverage through another group and:

- a) You and/or your dependent(s) are not longer eligible under your spouse's coverage because your spouse's employment or his or her group has been terminated;
- b) You are no longer eligible or included under your spouse's coverage due to legal separation or divorce;
- c) Your dependent is no longer eligible or included under your spouse's coverage due to legal separation or divorce or the dependent's age;
- d) You and/or your dependent(s) are no longer eligible under your spouse's coverage due to the death of your spouse;
- e) You are no longer eligible under your parent's coverage;
- f) You and/or your dependent(s) have coverage through another group but later become ineligible for coverage through that group (including COBRA participants).

In the above situations, you will not be treated as a Late Enrollee, provided you and/or your eligible dependent(s) enroll within 31 days of the termination date of your prior coverage and submit, as necessary, a letter from your spouse's former employer. This letter must indicate when the spouse's employment terminated, whether the spouse's employment terminated, when the spouse's coverage terminated, whether the spouse was enrolled under individual or family coverage, and a statement indicating that the employer contributed toward the cost of coverage. A similar letter is also required for dependents that are no longer eligible under their parent's coverage. Please contact your Group Administrator if you have any questions about these enrollment requirements.

Please return this form to:

Benefit Design Group, LLC
600 Washington Ave, Suite 104
Towson, MD 21204



Student Certification For Overage Dependent

I certify that my son/daughter, _____, is unmarried, is financially dependent, and is a full-time student enrolled in an accredited school. His/her date of birth is _____.

(Name of School)

(Address of School)

His/her enrollment at the above school began (month) _____ (day) _____ (year) _____; the expected graduation date is (month) _____ (year) _____. I understand that his/her protection under my coverage will terminate on the last day of the calendar month in which he/she ceases to be a full-time student as defined in the Certificate/Evidence of Coverage.

Date

Parent's Signature (Subscriber)

Parent's Identification Number

Please return this form to:
Benefit Design Group, LLC
600 Washington Ave, Suite 104
Towson, MD 21204



**COBRA SELECTION FORM
FOR CONTINUATION OF GROUP COVERAGE
WITH CAREFIRST BLUECROSS BLUESHIELD
OR CAREFIRST BLUECHOICE, INC.**

The Consolidated Omnibus Budget Reconciliation Act of 1985, also known as “COBRA”, requires that a group health plan sponsored by an employer who typically employs 20 or more employees offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) at group rates, in certain instances where coverage under the plan would otherwise end (“qualifying events”). Certain employer-maintained group health plans are exempt from COBRA, including small-employer plans, church plans (or tax-exempt organizations controlled by or affiliated with a church), and government plans (the Public Health Service Act governs governmental plans and contains parallel provisions of the federal law). Generally, if a member qualifies for continued coverage, he or she must pay the full cost of the applicable coverage during this period, and any applicable administrative fee. If the qualifying member wishes to continue coverage beyond this period, he or she may apply directly to CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. for direct pay non-group conversion coverage within 31 days after his or her continued group coverage ends. (Dental, drug and eye care programs are not available under the direct pay non-group conversion coverage.)

In general, an employer must notify the health plan administrator within 30 days after an employee’s “qualifying event” – death, job termination, reduced hours of employment, or eligibility for Medicare. In cases of divorce, legal marital separation, or a child’s loss of dependent status, it is the employee or his or her family’s responsibility to notify the health plan administrator within 60 days of the event. Once notified, the plan administrator then has 14 days to alert the employee and his or her family members about applicable rights to elect COBRA coverage. In turn, the employee, spouse, and children have 60 days to decide whether to buy COBRA coverage. **Please note that neither CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., nor their representatives act as the health plan administrator. This form is not an application for insurance. This form is for data collection purposes only. The above description of COBRA and COBRA procedures is general in nature.**

NAME OF PARTICIPANT(S): _____

IDENTIFICATION NO.: _____

SOCIAL SECURITY NO.: _____

PARTICIPANT’S ADDRESS: _____

HOME TELEPHONE NO.: () _____ WORK TELEPHONE NO.: () _____

GROUP NAME: _____ GROUP NUMBER: _____

PARTICIPANT'S STATEMENT

I understand and agree that in the event I cease to be eligible for continuation of group coverage, I will immediately notify the employer through whom I have continued coverage.

Signature of Participant and Date _____

TO BE COMPLETED BY PLAN ADMINISTRATOR

1. I HEREBY CERTIFY THAT THE PARTICIPANT HAS BEEN PROPERLY NOTIFIED OF ALL RIGHTS AND RESPONSIBILITIES AS DICTATED BY FEDERAL STATUTE.
2. TYPE OF QUALIFYING EVENT: _____
3. DATE CONTINUATION OF COVERAGE BECOMES EFFECTIVE FOR THE PARTICIPANT: _____
4. \$ _____ IS THE AMOUNT THAT THE PARTICIPANT HAS BEEN TOLD MUST BE REMITTED EACH MONTH FOR CONTINUATION OF GROUP COVERAGE.
5. CONTINUED GROUP COVERAGE MUST END NO LATER THAN: _____

Signature of Plan Administrator and Date _____

PLEASE RETURN THIS FORM TO:

CAREFIRST BLUECROSS BLUESHIELD / CAREFIRST BLUECHOICE, INC.
ENROLLMENT & BILLING
10455 MILL RUN CIRCLE
OWINGS MILLS, MD 21117
MAIL STOP 02-330

CUT5870-1S (3/02)

**SELECTION FORM
FOR CONTINUATION OF GROUP COVERAGE
WITH CAREFIRST BLUECROSS BLUESHIELD
OR CAREFIRST BLUECHOICE, INC.
FOR THOSE GROUPS NOT ELIGIBLE FOR COBRA**

This selection form is for continued group coverage in accordance with Maryland statute and Insurance Department regulations. These regulations enable you as an employee of the group or as a family member to continue your group coverage (including dental, drug or eye care coverage) for up to 18 months after you cease to be an eligible member of the group, as long as you meet certain requirements. You must pay the full cost of your coverage during this period. If you wish to continue coverage beyond this period, you may apply for non-group Conversion Coverage within 31 days after your continued group coverage ends. (Existing practices and policies for converting terminated group coverage to non-group Conversion Coverage will apply. Dental, drug and eye care programs are not available under the non-group Conversion Coverage). **Please note that neither CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., nor their representatives act as the health plan administrator. This form is not an application for insurance. This form is for data collection purposes only.**

NAME OF PARTICIPANT(S): _____

IDENTIFICATION NO.: _____

SOCIAL SECURITY NO.: _____

PARTICIPANT'S ADDRESS: _____

HOME TELEPHONE NO.: () _____ WORK TELEPHONE NO.: () _____

GROUP NAME: _____ GROUP NUMBER: _____

PARTICIPANT'S STATEMENT

I certify that, to the best of my knowledge and belief, the following statements are true:

1. My group coverage:
 - a) has been in force for at least three months;
 - b) did/will not terminate as a result of my failure to pay subscription charges (or any applicable portion).
2. My group coverage did/will not terminate because of my:
 - a) eligibility for or enrollment under Medicare;
 - b) attainment of any limiting age specified in the group contract.
3. I am not covered under or eligible for coverage under:
 - a) a health maintenance organization;
 - b) another group policy.

I understand and agree that in the event I cease to be eligible for Continuation of Group Coverage for any of the reasons set forth in items 2 and 3 above, I must notify my former employer immediately.

Signature of Participant and Date _____

TO BE COMPLETED BY PLAN ADMINISTRATOR

1. Date of termination of participant's employment: _____
2. \$ _____ is the amount I will collect and remit each month for the continuation of group coverage for this participant.

Signature of Plan Administrator and Date _____

PLEASE RETURN THIS FORM TO:

CAREFIRST BLUECROSS BLUESHIELD / CAREFIRST BLUECHOICE, INC.
ENROLLMENT & BILLING
10455 MILL RUN CIRCLE
OWINGS MILLS, MD 21117
MAILSTOP 02-330

CUT5862-1S (3/02)

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

Company Name _____

Company ID Number _____

I (we) hereby authorize BENEFIT DESIGN GROUP, hereinafter called COMPANY, to initiate debit entries to my (our) Checking Account indicated below at the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

Depository Name _____

Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name (s) _____

ID Number _____

Signature _____ Date _____

This arrangement does not change the premium due dates specified in the policy and it does not extend any of the grace or late periods for paying these premiums. The policy or policies will be placed on withhold care at the end of the grace or late period if the premium remains unpaid. This could occur if balances in your account were not sufficient to cover the debit amount.

BDG may stop the arrangement by written notice to you. The arrangement ends on the day BDG mails the notice.

If this agreement ends you will still be responsible for unpaid premiums which remain outstanding.

PLEASE ATTACH A COPY OF A BLANK VOIDED CHECK.