

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:	_____

BLUEFUND ONLY 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 _____ City _____ ST _____ Zip _____			Sex _____ Birth Date _____ M/F		Home Phone _____						
Full-Time Hire Date _____ Hours worked/wk _____			Marital Status Single _____ or Married _____									
Are you actively at work on a full-time basis for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No												
2	Occupation _____			Class _____			Annual Salary _____					
	Beneficiary _____			Relationship _____								
3	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)	
	Last First M.I.											
	Emp											
	Sp											
	Ch											
	Ch											
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? <input type="checkbox"/> Y <input type="checkbox"/> N Carrier: _____ (Gp# _____) Benefit \$ _____ Sup. \$ _____		
	<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child(ren) <input type="checkbox"/> Individual/adult <input type="checkbox"/> Family <input type="checkbox"/> Coverage Complimentary to Medicare (Individual Only/Not Eligible For HSA Funding <input type="checkbox"/> Waive Coverage			<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child(ren) <input type="checkbox"/> Individual/adult <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage			<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child(ren) <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. **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 is guilty of a crime and may be subject to fines and confinement in prison.** 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

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 ADDENDUM
TO BE COMPLETED ONLY WHEN ELECTING HSA/HRA BLUE FUND OPTIONS**

BY SIGNING THIS ENROLLMENT FORM, I HEREBY AUTHORIZE CAREFIRST BLUECROSS BLUESHIELD TO DISSEMINATE AND SHARE NON-HEALTH QUESTIONNAIRE INFORMATION CONTAINED ON THIS FORM WITH THE HEALTH SAVINGS ACCOUNT (HSA) CUSTODIAN OR HEALTH REIMBURSEMENT ACCOUNT (HRA) ADMINISTRATOR AFFILIATED WITH CAREFIRST BLUECROSS BLUESHIELD, INCLUDING ANY NAME OR ADDRESS CHANGES. I ALSO HEREBY AUTHORIZE THE HEALTH SAVINGS ACCOUNT (HSA) CUSTODIAN OR HEALTH REIMBURSEMENT ACCOUNT (HRA) ADMINISTRATOR TO DISSEMINATE AND SHARE NON-HEALTH QUESTIONNAIRE INFORMATION CONTAINED ON THE FORM WITH THE DEBIT CARD PROVIDER FOR THE SOLE PURPOSE OF ISSUANCE OF A DEBIT CARD(S) TO ACCESS MY HSA OR HRA FUNDS. I UNDERSTAND THAT DISSEMINATION OF INFORMATION TO ANY SUCH CUSTODIAN IS AT MY DIRECTION AND WITH FULL UNDERSTANDING. FURTHER THAT DISSEMINATION OF INFORMATION ON THIS FORM IS NECESSARY IN ORDER TO EFFECTUATE THE ESTABLISHMENT OF A HEALTH SAVINGS ACCOUNT OR HEALTH REIMBURSEMENT ARRANGEMENT IN MY NAME WITH THE HSA CUSTODIAN OR HRA ADMINISTRATOR. THE AUTHORIZATION SHALL CONTINUE UNTIL MY ENROLLMENT WITH CAREFIRST BLUECROSS BLUESHIELD TERMINATES OR AT ANY TIME THAT I PROVIDE A WRITTEN INSTRUCTION TO CAREFIRST BLUECROSS BLUESHIELD REVOKING THIS AUTHORIZATION OR IF THIS AUTHORIZATION TERMINATES BY OPERATION OR LAW.

I UNDERSTAND THAT I OR MY AUTHORIZED REPRESENTATIVE IS ENTITLED TO RECEIVE A COPY OF THIS FORM.

EMPLOYEE SIGNATURE: √ _____ **DATE:** _____