

**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 \_\_\_\_\_

<b>1</b>	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 _____ or Married _____																																																													
	Are you actively at work on a full-time basis for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																															
<b>2</b>	<b>TO BE COMPLETED ONLY IF APPLYING FOR LIFE/AD&amp;D, STD OR LTD COVERAGE</b>																																																															
	Occupation _____		Class _____ Annual Salary _____																																																													
	Beneficiary _____		Relationship _____																																																													
<b>3</b>	<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								
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	PARTICIPATING DENTIST/PROVIDER CODE (if required): NAME/CODE: _____																																																															
<b>4</b>	<b>Medicare:</b> Y _____ N _____ Date (Part A) ____/____/____ Date (Part B) ____/____/____ Medicare # _____ <b>TEFRA:</b> 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																																																															
<b>5</b>	<b>BENEFIT ELECTIONS:</b>																																																															
	<b>Medical Plan</b> (Gp# _____) Carrier: _____ Plan: _____		<b>Dental Plan</b> (Gp# _____) Carrier: _____ Plan: _____		<b>Vision Plan</b> (Gp# _____) Carrier: _____ Plan: _____		<input type="checkbox"/> <b>Life/AD&amp;D</b> <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"/> <b>STD</b> <input type="checkbox"/> Vol. STD <input type="checkbox"/> None Carrier: _____ (Gp# _____) Benefit/week \$ _____ <input type="checkbox"/> <b>LTD</b> <input type="checkbox"/> Vol. STD <input type="checkbox"/> None Carrier: _____ (Gp# _____) Benefit/ month \$ _____																																																									
<b>6</b>	<b>OTHER INSURANCE INFORMATION (Must Complete)</b>																																																															
	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.**

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**EMPLOYEE ELECTION ADDENDUM  
TO BE COMPLETED ONLY WHEN ELECTING HSA 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(S) AFFILIATED WITH CAREFIRST BLUECROSS BLUESHIELD, INCLUDING ANY NAME OR ADDRESS CHANGES. 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 ESTABLISHMENTL OF A HEALTH SAVINGS ACCOUNT IN MY NAME WITH THE HSA CUSTODIAN. THE AUTHORIZATION SHALL CONTINUE UNTIL MY ENROLLMENT WITH CAREFIRST BLUECROSS BLUESHIELD TERMINATEDS OR AT ANY TIME THAT I PROVIDE A WRITTEN INSTRUCTION TO CAREFIRST BLUECROSS BLUESHIELD REVOKING THIS AUTHORIZATION OR IF THIS AUTHORIZATION TERMINATEDS BY OPERATION OF LAW.**

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

EMPLOYEE SIGNATURE: ✓ \_\_\_\_\_ DATE: \_\_\_\_\_