EMPLOYEE Enrollment FORM

Fax to 866-767-7297

BMLL Billing # 310951-1
Effective Date ___________________
Team # R
Carrier Group # (See Coverage Boxes)
Employer with 20 or more employees? Yes

☐ New Hire ☐ Re-Hire ☐ COBRA/Continuation (Group Administered) ☐ Add Coverage

Last Name	**First Name**	**M.I.**	**Employer** Contemporary Holding Company
Street Address			**Social Security Number**
City / **State** / **Zip**	**Gender** ☐ Male ☐ Female		**Date of Birth**
Home Telephone # ( ) / **Business Telephone #** ( )	**Marital Status** ☐ S ☐ M ☐ D ☐ W	**Date of Marriage**	**Date Full-Time Employment Started:**
Are you actively working for the employer listed above (as defined in your insurance contract)? ☐ Yes ☐ No ☐ Full-time ☐ Part-time			**Hours Worked/Week**
Occupation			

MEDICAL PLAN

Enrollment – Check Below
Carrier **CareFirst**
Carrier Group # **14AA**

Select One

☐ BlueChoice HMO Option 3
☐ BlueChoice HMO HSA (ALT) Option 1
☐ BluePreferred PPO Option 3

AND Select One

☐ Employee Only
☐ Employee & Adult
☐ Employee & One Child
☐ Family

Short Term Disability

Enrollment - Check below

☐ **VOL. STD**
Carrier **Fort Dearborn**

Benefit $ ______________/ Wk.
(see brochure for benefit coverage and premiums)

Last, Full First, M.I.	Social Security Number	Birth Date	Sex	Student (Y/N)	Disabled (Y/N)	For HMO & HMO ALT Primary Care &OBGyn Carrier Assigned Provider # and name	Existing Patient (Y/N)
Employee							
Spouce							
Child							
Child							

1) Do you or your dependents have health coverage with another insurer? ____No ____Yes
If yes, what is Effective Date: ____________________ What is the name / policy # of other plan: ______________________
Will this policy continue? ____Yes ____No If no, what is the Termination date of this other plan:____________________

2) Are you covered by Medicare? ____No ____Yes
Effective date of Part A:_______________ Effective date of Part B: ________________ Medicare#:_______________

3) Is your spouse or dependent(s) covered by Medicare? ____No ____Yes Name of spouse or dependent covered: ___________
Effective date of Part A:_______________ Effective date of Part B: __________________ Medicare#:_______________

4) Waiver of Coverage: I certify that group Insurance coverage has been offered to me and I choose to waive coverage due to:
☐ Spousal Coverage ☐ Individual Coverage ☐ Military Coverage ☐ COBRA ☐ Medicare as primary under TEFRA ☐ No Coverage

CERTIFICATION: I hereby certify that I am the spouse, parent or legal guardian of the dependent(s) shown above. ***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.***

Voluntary STD benefits may be subject to pre-existing condition exclusions (please refer to your policy for more information).

I authorize my employer to make any necessary payroll deductions and also declare that any disability coverage in force and applied for, with respect to myself, is less than 75% of my current monthly earnings.

EMPLOYEE SIGNATURE ____**DATE**________________

EMPLOYER SIGNATURE/VERIFICATION____ **DATE** ________________