

Harford County Board of Education Enrollment/Change Form Please print or type.

FOR USE BY HUMAN RESOURCES MEDICAL GROUP # _____ EFFECTIVE DATE ____/____/____ DENTAL GROUP # _____ EFFECTIVE DATE ____/____/____

1 TYPE OF REQUEST - This election form is for one of the following:

- NEW COVERAGE CHANGE OPEN ENROLLMENT EMPLOYEE/MEMBER SOCIAL SECURITY NUMBER _____ / _____ / _____
 ANY INFORMATIONAL CHANGE (adding or deleting spouse or child) COBRA

2 APPLICANT INFORMATION

EMPLOYEE/MEMBER APPLICANT LAST NAME FIRST NAME MIDDLE INITIAL DATE OF HIRE/STATUS CHANGE

STREET ADDRESS CITY STATE ZIP WORK LOCATION

SEX DATE OF BIRTH HOME PHONE MARITAL STATUS MARRIED DIVORCED EFFECTIVE DATE OF
 M F ____/____/____ () SINGLE SEPARATED WIDOWED MARITAL STATUS CHANGE ____/____/____

3 HEALTH INSURANCE SELECTION (SELECT ONE)

ENROLLMENT LEVEL OF COVERAGE INDIVIDUAL ONE PARENT/ONE CHILD HUSBAND & WIFE FAMILY

1. PREFERRED PROVIDER OPTION (PPO) CORE 2. PREFERRED PROVIDER OPTION (PPO) PLUS 3. BLUECHOICE HMO (SPECIFY PCP BELOW)

I ELECT TO WAIVE HEALTH INSURANCE. I UNDERSTAND THERE IS NO REBATE PROGRAM FOR HEALTH INSURANCE.

4 DENTAL INSURANCE (ENROLLMENT LEVEL OF COVERAGE)

PPO OPTION: INDIVIDUAL ONE PARENT/ONE CHILD HUSBAND & WIFE FAMILY

PPO PREMIER: INDIVIDUAL ONE PARENT/ONE CHILD HUSBAND & WIFE FAMILY

I ELECT TO WAIVE DENTAL INSURANCE. I UNDERSTAND THAT THERE IS NO REBATE PROGRAM FOR DENTAL INSURANCE.

5 MEDICARE AND TEFRA INFORMATION

If Eligible Hospital Insurance Hospital Insurance Medical Insurance
 for Medicare: Claim No. _____ Effective Date ____/____/____ Effective Date ____/____/____

IF ACTIVELY EMPLOYED AND TEFRA APPLICABLE, COMPLETE PRIMARY CARRIER SELECTION SUBSCRIBER: BLUE CROSS OR MEDICARE SPOUSE: BLUE CROSS OR MEDICARE

6 OTHER HEALTH INSURANCE INFORMATION (TO BE COMPLETED IF APPLICABLE)

NOTE: THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE THIS SECTION WILL DELAY THE ENROLLMENT PROCESS.

ARE YOU, YOUR SPOUSE, OR ANY LISTED CHILDREN COVERED BY ANY OTHER HEALTH INSURANCE OR ANOTHER BLUE CROSS AND BLUE SHIELD PLAN?

YES NO

IF YES:	NAME OF POLICY HOLDER	POLICY NUMBER	EFFECTIVE		DOES THIS POLICY COVER YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO YOUR SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO YOUR CHILDREN? <input type="checkbox"/> YES <input type="checkbox"/> NO
			FROM		
	INSURANCE COMPANY	CITY AND STATE	THRU		

7 LIST EMPLOYEE AND COVERED DEPENDENT INFORMATION (SEE BELOW)

*IF ADDITIONAL, ATTACH SEPARATE SHEET.

CHECK MEDICAL AND/OR DENTAL COVERAGE →				MEDICAL, IF HMO SPECIFY PCP	DENTAL	SEX	DATE OF BIRTH	DISABLED
LAST NAME	FIRST	M.I.	RELATIONSHIP					
SS #								<input type="checkbox"/> Y <input type="checkbox"/> N
SS #								<input type="checkbox"/> Y <input type="checkbox"/> N
SS #								<input type="checkbox"/> Y <input type="checkbox"/> N
SS #								<input type="checkbox"/> Y <input type="checkbox"/> N
SS #								<input type="checkbox"/> Y <input type="checkbox"/> N

8 TERMINATION OF DEPENDENT(S)

MEDICAL DENTAL ← CHECK MEDICAL AND/OR DENTAL CODES

Name:	TERMINATION DATE: ____/____/____			Give correct Reason Code Reason _____	1. Divorce 2. Death 3. Child reached age limit	4. Entered military 5. Other
Name:	TERMINATION DATE: ____/____/____					

9 EMPLOYEE SIGNATURE, READ CAREFULLY

I have carefully read this application and agree to its terms. If I have selected medical coverage, I agree to the terms specified in the Benefit Guide. I authorize Harford County Board of Education to reduce my salary before taxes for the required contribution for the coverage(s) selected above. I understand that I can not change my coverages (including any waivers of coverage) except during an open enrollment period, unless I have a qualified family status change. I also understand that I will forfeit any Flexible Spending Account salary reductions or rebates for which eligible expenses have not been incurred during the Plan Year.

My statements on this application are, to the best of my knowledge, true and complete as of this date. I understand that failure to enter true and complete medical information may result in denial of benefits and voiding of coverage. I also certify that I am the spouse, parent or legal guardian of the dependents listed above. I agree that, in connections with any illness or injury for which I may seek health benefits, any health care provider is authorized to give CareFirst Blue Cross Blue Shield full information and records/copies related to treatment or care rendered to me or my eligible dependents. Such information is to be held confidential.

EMPLOYEE SIGNATURE _____

DATE _____