

**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)

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