

**MARYLAND POINT OF SERVICE  
EMPLOYEE/MEMBER ENROLLMENT  
OR CHANGE FORM**

**THIS IS NOT  
AN APPLICATION  
FOR INSURANCE**



Account No.				

**1 EMPLOYER INFORMATION: To be completed by the employer**

Employer	Phone (    ) _____ - _____	Group Number: _____
Effective Date Requested ____/____/____	Date of Hire ____/____/____	Medical: _____ Dental: _____ Medical Option: _____
<b>Check all that apply</b> Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired		Vision: _____ Other: _____

**2 TYPE OF REQUEST**

New Subscriber     COBRA - Relationship to employee/member     Spouse     Child  
 Coverage Change  
 Any Informational Change (name or address change; adding or deleting spouse or child)

Employee/Member Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_

**3 SUBSCRIBER INFORMATION**

Employee Last Name	First Name	Middle Initial
Street Address	City	State      Zip
Social Security Number ____/____/____	Home Phone (    ) _____ - _____	Work Phone (    ) _____ - _____
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____	Marital Status <input type="checkbox"/> Married/Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
		Employee Occupation
		Effective Date of Status ____/____/____

**4 MEDICARE/TEFRA INFORMATION (to be completed if applicable)**

Are You Eligible For Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: _____ - _____ - _____	Hosp. Eff Date (Part A) ____/____/____	Med. Eff Date (Part B) ____/____/____
Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: _____ - _____ - _____	Hosp. Eff Date (Part A) ____/____/____	Med. Eff Date (Part B) ____/____/____
Child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: _____ - _____ - _____	Hosp. Eff Date (Part A) ____/____/____	Med. Eff Date (Part B) ____/____/____

**Check Here For TEFRA If All of the Following Apply:**

- You are 65 or older • You are eligible for Medicare • You are actively employed
- You are continuing group coverage with CareFirst BlueCross BlueShield as primary carrier
- Your employer meets Tefra requirements\*. (Groups of 20 or more employees).

**\*If unknown, your personnel department should be able to assist you with this information.**

**I am enrolling for:**  
 Self     Spouse

**5 OTHER HEALTH INSURANCE INFORMATION**

**Note: This information is subject to verification. Failure to complete this section may delay claims payment.**

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 Date: From:____ Thru:____ 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
	Insurance Company	City and State	

CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

**6 SUBSCRIBER & DEPENDENT INFORMATION: Please list all persons to be covered.**

**COVERAGE LEVEL – Please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section to avoid delays in processing this Enrollment Form.**

**COVERAGE LEVELS OF SUBSCRIBER AND DEPENDENTS, IF APPLICABLE**

**Coverage Level for Medical Option (if applicable and your employer has elected to offer):**

- Individual  Individual and Adult  Individual and Child  Family  Coverage Complementary to Medicare (Individual-only)

**Coverage Level for Dental Option (if applicable and your employer has elected to offer):**

- Individual  Individual and Adult  Individual and Child or  Individual and Child(ren) (Regional Product only)  Family

**Coverage Level for Prescription Drug Option (if applicable and your employer has elected to offer):**

- Individual  Individual and Adult  Individual and Child  Family

**Coverage Level for BlueVision Plus Option (if applicable and your employer has elected to offer):**

- Individual  Individual and Adult  Individual and Child  Family

**SUBSCRIBER INFORMATION**

Last	First	MI	Type of Coverage	Relationship	Sex	Date of Birth	Social Security Number	Existing Patient	PCP ID Number	Primary Care Physician
			<input type="checkbox"/> Medical <input type="checkbox"/> Traditional Dental <input type="checkbox"/> Preferred Dental <input type="checkbox"/> Prescription Drug <input type="checkbox"/> BlueVision Plus	Subscriber				<input type="checkbox"/> Yes <input type="checkbox"/> No		

**DEPENDENT INFORMATION: If the subscriber has more than four dependents, please list the additional dependents on a separate Enrollment Form.**

Last	First	MI	Type of Coverage	Relationship	Sex	Date of Birth	Social Security Number	Existing Patient	PCP ID Number	Primary Care Physician
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drug <input type="checkbox"/> BlueVision Plus					<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drug <input type="checkbox"/> BlueVision Plus					<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drug <input type="checkbox"/> BlueVision Plus					<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drug <input type="checkbox"/> BlueVision Plus					<input type="checkbox"/> Yes <input type="checkbox"/> No		

Is anyone listed above a student or disabled?  YES  NO

If the answer is YES, please list the name of the person \_\_\_\_\_

If a full-time student, please attach student certification form. If yes, disabled, please attach disability certification form and supporting documentation.

**7 TERMINATION OF DEPENDENTS REASON CODES**

<b>DO NOT USE THIS SECTION TO CHANGE COVERAGE.</b>		1. Divorce 2. Death 3. Child reached age limit 4. Child no longer student 5. Entered military 6. Other
Name: _____	Termination Date ____/____/____	
Give correct reason code: _____		
Name: _____	Termination Date ____/____/____	
Give correct reason code: _____		

I hereby enroll, on behalf of myself and each dependent listed above, for the health coverage indicated. If this Form is accepted, coverage will be provided according to terms and conditions of the health care contract between CareFirst BlueCross BlueShield and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution.

**I have carefully read this 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.**

**THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE ANY SECTION MAY DELAY CLAIMS PAYMENT.**

Employee's/Member's/Enrollee's Signature \_\_\_\_\_ Date \_\_\_\_\_ Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_