

Small Group Regional Dental Information Form (CFMI)

Date Prepared: _____		Facets Group ID (CareFirst to assign): _____	
Effective Date: _____		Federal Tax ID #: _____	
Group(Account) Name: _____		SIC Code: _____	
Physical Address: Street: _____			
City: _____	State _____	Zip: _____	County: _____
Group(Account) Billing Address (if different than Physical Address):			
Street: _____			
City: _____	State _____	Zip: _____	
Group Administrator Name: _____		Phone No.: _____	
Street: _____			
City: _____	State _____	Zip: _____	
Firm Executive Name: _____		Phone No.: _____	
Street: _____			
City: _____	State _____	Zip: _____	
Enrollment Requirement:			
<input type="checkbox"/> the date of hire		<input type="checkbox"/> the first day of the month following 60 days of employment	
<input type="checkbox"/> the first day of the month following date of hire		<input type="checkbox"/> the first day of the month following 90 days of employment	
<input type="checkbox"/> the first day of the month following 30 days of employment			
<input type="checkbox"/> Other _____			
Dependent/Student Eligibility:			
Dependent/Student Eligibility for SEGO groups will be 19 End of Month / 23 End of Month			
HB8 Elections:			
Company offering coverage to Part-Time employees?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Company offering coverage to employees with other insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Company offering coverage to retired employees? **		<input type="checkbox"/> Yes	<input type="checkbox"/> No
**Only applies to groups renewing PPN and/or MPOS medical electing to renew into Regional Dental or have existing Freestanding CFMI dental renewing into Regional Dental.			
Group Enrollment: <input type="checkbox"/> Parallel –must enroll in medical and dental at same coverage level or no coverage (i.e. P/C medical and P/C dental)			
<input type="checkbox"/> Non-Parallel - allows the employee to enroll differently in medical and dental (i.e. Family medical and Individual dental)			
Broker Name: _____		Broker Social Security # _____	
Existing CareFirst Dental Group Number: _____			
Sales Rep Name: _____	Date: _____	AI Tech Name: _____	Date: _____