

- New Enrollee       Coverage Change       Waiver (See Section 6)  
 COBRA/MSE Enrollee       Information Update



**GROUP BENEFIT SERVICES, INC.**  
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## EMPLOYEE ELECTION FORM

(This is not an application for insurance)

Every Item Must Be Completed

| 1. EMPLOYEE INFORMATION (Your employer will complete the shaded boxes in this section)  |  |                  |               |                  |                        | Employer Section               |                                |
|---|--|------------------|---------------|------------------|------------------------|--------------------------------|--------------------------------|
| Last Name   |  | First Name       |               | M.I.             | Social Security Number |                                | Effective Date(s):             |
| Street Address  |  |                  |               |                  | Date of Hire           |                                | Medical: _____ Life/STD: _____ |
| City  |  |                  | State         | Zip Code         | Hours Worked Per Week  |                                | Dental: _____ LTD: _____       |
| Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female  |  |                  | Date of Birth | Home Phone #     | Business Phone #       | Extension                      | GBS Account Number             |
| Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Widowed |  | Date of Marriage |               | Name of Employer |                        | Annual Salary   Effective Date |                                |
|   |  |                  |               |                  |                        | Benefit Class/Occupation       |                                |

| 2. GENERAL INFORMATION (Complete entire line for all listed) |           |            |      |               |                   | IF HMO OR POS PLAN |                         |                       | Medical      | Dental | Vision | Debit Card |       |
|--|-----------|------------|------|---------------|-------------------|--------------------|-------------------------|-----------------------|--------------|--------|--------|------------|-------|
|  | Last Name | First Name | M.I. | Date of Birth | Social Security # | Sex                | Primary Care Provider # | Current Patient (Y/N) | Dentist Code | (Y/N)  | (Y/N)  | (Y/N)      | (Y/N) |
| Self   |           |            |      |               |                   |                    |                         |                       |              |        |        |            |       |
| Sp/DP  |           |            |      |               | - -               |                    |                         |                       |              |        |        |            |       |
| Child  |           |            |      |               | - -               |                    |                         |                       |              |        |        |            |       |
| Child  |           |            |      |               | - -               |                    |                         |                       |              |        |        |            |       |
| Child  |           |            |      |               | - -               |                    |                         |                       |              |        |        |            |       |

Are any of your dependents Disabled (Y/N) \_\_\_\_\_ or Full-Time Student (Y/N) \_\_\_\_\_ If so, name of dependent \_\_\_\_\_

### 3. OTHER HEALTH/DENTAL INSURANCE INFORMATION (You must complete this section or claims may be denied)

Do you or your dependents described on this form have "health" or "dental" coverage with another insurer?  Yes  No Effective Date: \_\_\_\_\_ Term Date: \_\_\_\_\_

Who is covered?  Self  Spouse  All Other Carrier Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Will you or your dependents continue coverage with other insurer?  Yes  No Other coverage is through  Individual Policy  Spouse's Employer

Are you covered by Medicare:  No  Yes Effective Date (Part A) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Part B) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Medicare # \_\_\_\_\_

Are any of your dependents covered by Medicare:  No  Yes Effective Date (Part A) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Part B) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Medicare # \_\_\_\_\_

### 4. BENEFIT ELECTION (Indicate level of coverage elected for each benefit offered by your employer)

| MEDICAL PLAN  | DENTAL PLAN  | VISION PLAN  | LIFE INSURANCE   | SHORT TERM DISABILITY   | LONG TERM DISABILITY  | GBS ADVANTAGE HRA  |
|---|--|--|--|---|---|--|
| Carrier: _____<br>Plan: _____<br>Group# _____<br><input type="checkbox"/> Individual<br><input type="checkbox"/> Individual & 1 Child<br><input type="checkbox"/> Individual & Adult<br><input type="checkbox"/> Individual & Children<br><input type="checkbox"/> Family<br><input type="checkbox"/> Comp. to Medicare (Ind. Only and Benefit Coverage Only, Not Eligible for HSA.)<br><input type="checkbox"/> NONE | Carrier: _____<br>Plan: _____<br>Group# _____<br><input type="checkbox"/> Individual<br><input type="checkbox"/> Individual & 1 Child<br><input type="checkbox"/> Individual & Adult<br><input type="checkbox"/> Individual & Children<br><input type="checkbox"/> Family<br><input type="checkbox"/> NONE | Carrier: _____<br>Plan: _____<br>Group# _____<br><input type="checkbox"/> Individual<br><input type="checkbox"/> Individual & 1 Child<br><input type="checkbox"/> Individual & Adult<br><input type="checkbox"/> Individual & Children<br><input type="checkbox"/> Family<br><input type="checkbox"/> NONE | Carrier: _____<br>Plan: _____<br>Group# _____<br><input type="checkbox"/> Life Insurance/AD&D<br><input type="checkbox"/> Supplemental Life Benefit: _____<br><input type="checkbox"/> Dependent Life<br><input type="checkbox"/> NONE | Carrier: _____<br>Plan: _____<br>Group# _____<br><input type="checkbox"/> Short Term Disability<br><input type="checkbox"/> Voluntary STD Benefit: _____<br><input type="checkbox"/> NONE | Carrier: _____<br>Plan: _____<br>Group# _____<br><input type="checkbox"/> Long Term Disability<br><input type="checkbox"/> Voluntary LTD<br><input type="checkbox"/> NONE | Carrier: _____<br>Plan: _____<br>Group# _____<br><input type="checkbox"/> Individual<br><input type="checkbox"/> Individual & 1 Child<br><input type="checkbox"/> Individual & Adult<br><input type="checkbox"/> Individual & Children<br><input type="checkbox"/> Family<br><input type="checkbox"/> NONE |

| 5. LIFE INSURANCE BENEFICIARY: |              |   |
|--------------------------------|--------------|---|
| Beneficiary Name               | Relationship | % |
|                                |              |   |

### Important - Special Carrier Information/Waiver Information Below - Please Read and Check All That Apply

- CFS HSA/HRA Blue Fund**  
By signing this Enrollment Form, I hereby authorize CareFirst BlueCross BlueShield to disseminate and share non-health questionnaire information contained on this Form with the Health Savings Account (HSA) custodian or Health Reimbursement Arrangement (HRA) administrator affiliated with CareFirst BlueCross BlueShield, including any name or address changes. I also hereby authorize the Health Savings Account (HSA) custodian or Health Reimbursement Account (HRA) administrator to disseminate and share non-health questionnaire information contained on this Form with the debit card provider for the sole purpose of issuance of a debit card(s) to access my HSA or HRA funds. I understand that dissemination of information to any such custodian or administrator is at my direction and with full understanding. Further that dissemination of information on this Form is necessary in order to effectuate the establishment of a Health Saving Account or Health Reimbursement Arrangement in my name with the HSA custodian or HRA administrator. The authorization shall continue until my enrollment with CareFirst BlueCross BlueShield terminates or at any time that I provide a written instruction to CareFirst BlueCross BlueShield revoking this authorization or if this authorization terminates by operation of law. I understand that I or my authorized representative is entitled to receive a copy of this Form.
- GBS Advantage HRA**  
I understand that my elections are binding for the entire Plan Year and cannot be revoked, modified or amended unless due to a limited family status change. Under penalty of perjury I agree to use the debit card solely for the purchase of eligible expenses not covered by any other plan. I am responsible for providing proof to support reimbursed expenses and agree that any reimbursed expenses later discovered to be ineligible may be deducted from my paycheck by my employer. I authorize the release of claims information to my employer and Group Benefit Services, Inc.

### 6. WAIVER

- I hereby certify that the benefits provided by my Employer have been explained to me, that I have been given an opportunity to elect coverage and that I voluntarily decline to participate in the benefits checked "NONE" at this time. I understand that I may be required to wait until the next open enrollment period (if applicable) or until a Special Enrollment event for medical or dental coverage, or be required to provide evidence of insurability for life or disability benefits.

Reason for Waiver:  Coverage Elsewhere      Carrier Name: \_\_\_\_\_       Not Interested

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

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. I certify that I am the spouse, parent, legal guardian (or the dependent has been placed in my home for adoption) of the dependents listed above and they are dependent upon me for primary support as defined by the IRS.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

EMPLOYER SIGNATURE/VERIFICATION: \_\_\_\_\_ DATE: \_\_\_\_\_