

**ENROLLMENT APPLICATION**

Benefits Administered by CareFirst Administrators

New  
 Change

Employee - If you are applying for coverage with your employer's benefit plan, please complete Parts 2 - 6. If you do not desire coverage under your employer's plan, please complete Parts 2, 3 (as applicable) and 7. **Please print clearly.** Incomplete and/or illegible forms will be returned.

**Part 1 - Employment Information (TO BE COMPLETED BY THE EMPLOYER)**

a) Company Name: ALLEN IMPACT b) Subgroup: \_\_\_\_\_  
c) Effective Date: \_\_\_\_\_ d) Employee Date of Hire \_\_\_\_\_  
e) Salary: \_\_\_\_\_

**Part 2 - Employee Information**

a) Social Security Number: \_\_\_\_\_  
b) Name: Last \_\_\_\_\_ c) First: \_\_\_\_\_ d) Middle: \_\_\_\_\_  
e) Street: \_\_\_\_\_ f) Gender:  Male  Female  
g) City: \_\_\_\_\_ h) Date of Birth: \_\_\_\_\_  
i) State: \_\_\_\_\_ j) Zip: \_\_\_\_\_ k) Status:  Single  Married  Divorced  Widowed

**Part 3 - Coverage Information**

**a) Medical /Prescription Plan**      **Coverage level**      **b) Dental Plan**      **Coverage level**  
 Plan A       Employee Only       National Dental       Employee Only  
 Plan B       Employee + Child(ren)            Employee + Child(ren)  
                          Employee + Spouse            Employee + Spouse  
                          Employee + Family            Employee + Family  
  
**c) Vision Plan**      **Coverage Level**  
 Employee Only  
 Employee + Child(ren)  
 Employee + Spouse  
 Employee + Family

**Part 4 - Dependent Information** - Complete below unless you elected Single coverage in Part 3 above

Last Name	First Name	Middle Name	Date of Birth	Relationship	Gender	Social Security Number
a)			b)	c) Spouse	d)	e)
f)			g)	h)	i)	j)
k)			l)	m)	n)	o)
p)			q)	r)	s)	t)
u)			v)	w)	x)	y)

**Part 5 - Other Coverage Information**

a) Are you or any member of your family covered by any other group insurance, HMO Plan, or Federal program including Medicare?  
**Medical**  Yes  No; **Dental**  Yes  No; **Vision**  Yes  No; **Prescription**  Yes  No (Complete below for Medicare)

b) If yes, Name of Carrier: \_\_\_\_\_ c) Policy ID#: \_\_\_\_\_  
d) Address: \_\_\_\_\_  
e) Effective Date: \_\_\_\_\_  
f) Policyholder Name: \_\_\_\_\_

g) Are family members covered?  Yes  No      If yes, which ones?  Employee  Spouse  Children  
If yes, is this Plan Primary (P) or Secondary (S) for:  P  S Employee       P  S Spouse       P  S Children

**Medicare Part A**  Yes  No; **Medicare Part B**  Yes  No; **Medicare Part D**  Yes  No

b) If yes, Name of Carrier: \_\_\_\_\_ c) Health Insurance Claim# (HIC#): \_\_\_\_\_  
d) Address: \_\_\_\_\_  
e) Effective Date Part A: \_\_\_\_\_ Effective Date Part B: \_\_\_\_\_ Effective Date Part D: \_\_\_\_\_  
f) Policyholder Name: \_\_\_\_\_

g) Are family members covered?  Yes  No      If yes, which ones?  Employee  Spouse  Children  
If yes, is this Plan Primary (P) or Secondary (S) for:  P  S Employee       P  S Spouse       P  S Children

**Part 6 - Request for Group Insurance**

I have attached a copy of my certificate(s) of creditable coverage that may reduce my pre-existing waiting period  Yes  No  
I hereby apply for insurance to which I am entitled issued by the Group. I meet the eligibility requirements of this plan and authorize the deduction from my earnings of any contribution I may be required to make toward the cost of the plan.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 7 - Waiver for Group Health Insurance**

Check the appropriate box below and then sign and date at the bottom.

I am declining coverage under this Plan as I currently have coverage under another group health plan.  Yes  No

I hereby certify that I have been offered an opportunity to become covered under the benefit plan sponsored by my employer and I have, on behalf of myself, and/or my spouse, and/or children, decided NOT to take advantage of this offer.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer's Signature/Verification: \_\_\_\_\_ Date: \_\_\_\_\_