501 Fairmount Ave Suite #400
Towson, MD 21286
1-800-825-6650

Maryland SHOP
Employer Choice Enrollment Guide (2-50)

We are pleased to provide you with detailed instructions to assist you in enrolling your Group. We must receive a completed group prior to the 12th of the month for a 1st of the month effective date. Thank you for your business.

___ To verify SHOP eligibility, you must complete the form online at:
https://www.marylandhealthconnection.gov/small-business/shop-eligibility/

___ Group Insurance Agreement (GIA/R.3/18)

___ **MHBE SHOP Direct Enrollment SHOP Plans Employer Carrier Application**-If the group checks **Yes** to Cobra or MD Continuation on page 4 of the Employer Application, you must contact your BenefitMall Broker Sales Representative to select vendor and obtain a contract. There is a separate cost associated with these services.

___ **Maryland SHOP Direct Enrollment SHOP Plans Employee Eligibility and Election Form**- for all eligible employees. Employees waiving coverage must complete an election form in full, including the name and policy number of the other carrier.

___ Copy of Maryland SHOP sold proposal

___ Binder check for 1st month's premium made payable to BenefitMall. (a live check must be submitted with the paperwork)

___ ACH Authorization Form to be completed by the group is they want to pay by ACH funds transfers.

___ The most recent quarter's filed MD unemployment quarterly Wage/Tax Report

- A completed W-4 Federal form is required for all employees not on the Wage and Tax Statement or for employees handwritten at the bottom of the statement.
- A payroll register must be submitted for any newly hired employee not on the Wage and Tax.
- Proper tax documentation is required for officers and business owners not appearing on the Wage and Tax Statement.

Note: This document is to be used solely as a guide to assist you in enrolling your group. Please refer to Carrier documentation for additional requirement.

MARYLAND SHOP ALL CARRIERS-EMPLOYER CHOICE 10-4-2018

GROUP INSURANCE AGREEMENT

☐ New Group ☐ Existing Group ☐ Change Coverage ☐ Add Coverage

BML Billing #_____ Effective Date _____

PO Box 42827
Baltimore, MD 21284-2827
Fax: (410) 512-3984

Company Address Information

Company Name			Parent Company/Affiliation (if applicable)
Billing Address			
Street	**City**	**State**	**Zip**
Physical Location *(if different)*			
Street	**City**	**State**	**Zip**
NOTE: *A street address is often required for contract delivery. If billing address differs from address on Wage &Tax, additional documentation is required.*			

Billing

☐ ***PLEASE CHECK HERE IF YOU DO NOT WANT BENEFITMALL TO BILL THIS GROUP***

Company Contact Information

BILLING/ENROLLMENT CONTACT NAME	TITLE	PHONE	FAX	E-MAIL
RENEWAL CONTACT NAME				
DECISION-MAKER CONTACT NAME				

Company Information

FEDERAL TAX ID#	ASSOCIATION (if applicable)	SIC CODE/INDUSTRY TYPE
TYPE OF ORGANIZATION		NUMBER OF FULL TIME EMPLOYEES
IS COVERAGE OFFERED TO : Domestic Partner? ☐ Y ☐ N Part-time employees? ☐ Y ☐ N Employees with coverage elsewhere? ☐ Y ☐ N		TOTAL NUMBER OF PART-TIME EMPLOYEES
Is this organization subject to COBRA or State Continuation Laws? ☐ Y ☐ N Company market segment (number of total employees full and part time): 1-9 ☐ 10-19 ☐ 20-50 ☐ 51-199 ☐ 200+ ☐		PRIOR COVERAGE: ☐ Y ☐ N Carrier Name: _____

Plan Information

TYPE	*CARRIER*	*PLAN*	*MD SMALL GROUP BENEFITS? Y/N*	*NEW EMPLOYEE WAITING PERIOOD*	*EMPLOYER CONTRIBUTION % OR AMT*	*# of EMPLOYEES ENROLLING*	*# of EMPLOYEES WAIVING*
HEALTH							
HEALTH							
HEALTH							
DENTAL							
VISION							
LIFE							
STD							
LTD							
LBHP							

GROUP INSURANCE AGREEMENT

BenefitMall Administrative Procedures, Guidelines & Compensation

Billing and Premium Payments
BenefitMall will generate your premium statement on or about the 7th of the month prior to the due date. All checks should be made payable to BenefitMall and are due on the first of the month. A $25.00 fee will be charged for a check returned for non-payment for any reason.

Reminder notices will be sent on or about the 10th of the month in which the premium is due. Termination notices will be sent once the grace period has passed. If your coverage is terminated due to non-payment of premium, you must re-apply for reinstatement.

Depending upon the carrier, certain guidelines must be met in order for reinstatement to be approved. Full payment of past due premium, current due premium as well as future premium may be required. BenefitMall will charge a $50.00 reinstatement fee.

Enrollment
Applications for new hires who have met your company's mandated eligibility period as well as employees enrolling due to a lifestyle change should be submitted to BenefitMall within 30 days of the Qualifying Event.

In order to ensure the enrollment is processed prior to your premium statement being generated, please submit all applications to BenefitMall prior to the 25th of the effective month.

Company Termination
If your company chooses to terminate coverage through BenefitMall, it is requested that (30) days advance written notice be given. If your company fails to provide written notification prior to the first of the month in which the coverage is effective, your company may be liable for an additional month's premium.

Compensation
Your broker is compensated for his/her services through commission(s) and/or fees from the carrier(s) or supplier(s) selected.

Please refer to your Employer Administrative Reference Guide for complete details on BenefitMall Administrative Procedures, Guidelines & Compensation.

If you have not received an Employer Administrative Reference Guide, please contact Customer Service at (800) 825-6650.

I have read, understand and verify that the information on this form is accurate.

Company Official Signature	*Title*	*Date*
Agent/Broker Signature	*Title*	*Date*
BenefitMall Representative	*Title*	*Date*

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Maryland Health Connection - Direct Enrollment SHOP Plans

Employer / Carrier Application (not a SHOP Eligibility Application)

Group Number	

Company Information

Legal Company Name	Doing Business As (if Applicable)		
Physical Street Address (PO Box not acceptable)	City	State	ZIP
Billing Address (if different from physical)	City	State	ZIP
Mailing Address (if different from physical or billing)	City	State	ZIP
Phone Number	Fax Number		

Does this business have multiple locations?
If so, please attach sheet with all locations with Street Address, City, State and ZIP and number of employees at each broken down by Full-time, Part-time, Retired, COBRA or State Continuees, 1099, Union, Seasonal, Other.

Company Group Contact: Name and Title		Email	Phone Number
Billing Contact: Name and Title (if different from above)		Email	Phone Number
Enrollment Contact: Name and Title (if different from above)		Email	Phone Number

Chief Executive Officer	Organization type: (C-Corp, S-Corp, Non-Profit, Partnership, Sole Proprietor, LLC, LLP, Other):		
SIC Code	Nature of Business	Federal Tax ID	Date Established

Group Information

		Yes	No
Is your company under 50 full-time equivalent employees (FTEs)? If so, number of FTEs?			
Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?	Details:		
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?			
Are there any associated companies to be included with this group that are commonly owned?			
Is your company a branch of another company, or does your company have branch offices?			
Do you use the services of a payroll company? If "Yes", provide the name of the payroll company:	Payroll Company:		

Prior Insurance Information

Please list any coverage with any carrier in the past 12 months

	Name of Carrier (Corporate Name)	Policy # (if available)	Coverage Begin Date (MM/DD/YY)	Coverage End Date (MM/DD/YY) (write current, if current)
Medical Carrier				
Dental Carrier				

	Yes	No
Does your group have Worker's Comp: If Yes, what is the Carrier Name:		
Are all employees covered by Worker's Compensation? If No, explain below:		
Is Health Plan Primary and Medicare Secondary? If your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, than your health plan is primary and Medicare is Secondary. Otherwise, Medicare is primary.		

Medical Loss Ratio (MLR) Classification

		Yes	No
Subject to ERISA?	(If no, please indicate why):		
Non-Federal Government Group?			

For Non-ERISA and non-government groups, you may be subject to additional addendums dependent on carriers which would be provided to you.

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Plan Selection

For Employer Choice: Please select one participating insurance carrier for your company. All metal levels will be available for the chosen carrier.

For Employer Choice: Please select plans across participating insurance carriers for your company. No more then two consecutive metal levels are allowed.

Requested Effective Date:

Please select the desired method of Plan selection

Employee Choice						Employer Choice					
Bronze	☐	Silver	☐	Gold	☐	Platinum	☐				

MEDICAL and DENTAL PLAN CHOICES

Aetna Health, Inc.	☐ Aetna Bronze HMO 5000 80% HSA	☐ Aetna Silver HMO 4500 80%	☐ Aetna Gold HMO 2500 90%	**Aetna Life Insurance Company**	☐ Aetna Bronze PPO 5000 80/60 HSA	☐ Aetna Silver PPO 4500 80/60	☐ Aetna Gold PPO 2500 90/70
CareFirst BlueChoice, Inc.	☐ BlueChoice HMO 1000	☐ BlueChoice HMO HSA/HRA 2000	☐ BlueChoice HMO Referral HSA/HRA 5500	**CareFirst of Maryland, Inc.**	☐ BluePreferred PPO 1000 90%/70%	☐ BluePreferred PPO HSA/HRA 2000 80%/60%	☐ BluePreferred PPO HSA/HRA 5500
Group Hospitalization and Medical Services, Inc.	☐ BluePreferred PPO 1000 90%/70%	☐ BluePreferred PPO HSA/HRA 2000 80%/60%	☐ BluePreferred PPO HSA/HRA 5500				
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	☐ KP MD Platinum 0/10/Dental	☐ KP MD Platinum 500/20/Dental	☐ KP MD Gold 0/20/Dental	☐ KP MD Gold 1000 / 20 / Dental	☐ KP MD Gold 1400/0%/HSA /Dental	☐ KP MD Silver 1500/30/HSA /Dental	☐ KP MD Silver 2500/40/Dental
	☐ KP MD Bronze 5500/50/Dental	☐ KP MD Bronze 5750 / 30 / 20% / HSA / Dental	☐ KP MD Bronze 5500/50/POS /Dental	☐ KP MD Bronze 6550/0%/HSA /Dental	☐ KP MD Silver 1700/40/Dental	☐ KP MD Silver 2500/30/HSA/Dental	
UnitedHealthcare of the Mid-Atlantic, Inc.	☐ UHC Core Essential HSA HMO Bronze 4000-2	☐ UHC Core Essential HSA HMO Gold 1500-2	☐ UHC Core Essential HSA HMO Bronze 6650-2	☐ UHC Core Essential HSA HMO Silver2250-2	☐ UHC Navigate HSA HMO Gold 2250-2	☐ UHC Navigate HSA HMO Bronze 4000-2	☐ UHC Navigate HSA HMO Bronze 6650-2
	☐ UHC Navigate HSA HMO Silver 3500-2	☐ UHC Core Essential HMO Bronze 5250-2	☐ UHC Navigate HMO Bronze 5250-2	☐ UHC Navigate HMO Silver 2000-1	☐ UHC Navigate HMO Gold 750-1	☐ UHC Core Essential HMO Silver 2000-2	☐ UHC Core Essential HMO Gold 750-2
UnitedHealthcare Insurance Company	☐ UHC Choice Plus HSA POS Gold 1400-2	☐ UHC Choice Plus HSA POS Gold 1500-2	☐ UHC Choice Plus HSA POS Silver 2250-2	☐ UHC Choice Plus HSA POS Bronze 4000-2	☐ UHC Choice Plus HSA POS Silver 2600-2	☐ UHC Choice Plus POS Platinum 250-6	☐ UHC Choice Plus POS Gold 750-2
	☐ UHC Choice Plus POS Silver 2000-2	☐ UHC Choice Plus POS Gold 1500-2	☐ UHC Choice Plus POS Platinum 0-2	☐ UHC Choice Plus POS Platinum 0-4			
Optimum Choice, Inc.	☐ UHC OCI HSA HMO Bronze 4000-2	☐ UHC OCI HSA HMO Gold 1500-2	☐ UHC OCI HSA HMO Silver 2250-2	☐ UHC OCI HSA HMO Bronze 6650-2	☐ UHC OCI HSA HMO Gold 1400-2	☐ UHC OCI HSA HMO Silver 2600-2	☐ UHC OCI HMO Bronze 5250-2
	☐ UHC OCI HMO Silver 2000-2	☐ UHC OCI HMO Gold 750-2	☐ UHC OCI HMO Gold 1500-2	☐ UHC OCI HMO Platinum 0-2	☐ UHC Choice EPO Platinum 0-4	☐ UHC OCI HMO Platinum 0-6	

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MAMSI Life and Health Company	☐ UHC Choice HSA EPO Bronze 4000-2	☐ UHC Choice HSA EPO Bronze 6650-2	☐ UHC Choice HSA EPO Gold 1400-2	☐ UHC Choice HSA EPO Gold 1500-2	☐ UHC Choice HSA EPO Silver 2250-2	☐ UHC Choice HSA EPO Gold 1400-4	☐ UHC Choice HSA EPO Silver 2600-2
	☐ UHC Choice EPO Platinum 250-2	☐ UHC Choice EPO Bronze 5250-2	☐ UHC Choice EPO Silver 2000-2	☐ UHC Choice EPO Gold 1500-2	☐ UHC Choice EPO Platinum 0-2	☐ UHC Choice EPO Platinum 0-4	☐ UHC Choice Plus POS Platinum 0-2

Dominion Dental Enrollment	Plan Choice:		☐ Individual	☐ Individual & Adult	☐ Individual & 1 Child	☐ Individual & Children	☐ Family

Employer Contribution

Employer Contribution	Medical (Percentage Contribution)	Medical (Fixed Dollar Contribution)	Dental (Percentage Contribution)	Dental (Fixed Dollar Contribution)
For Employee	%	$	%	$
For Dependents	%	$	%	$

Employer POS Option

	Yes	No
Employer wants medical POS Option offered to its employees		
Employer wants dental POS Option offered to its employees		

Employee Eligibility

Eligibility date for enrollment will be the first day of the policy month following the waiting period, unless the 90 days following date of hire option. Policy month refers to the contract effective date of the 1st or 15th. 90 days following date of hire option would result in an effective date an exact 90 days from the employee's date of hire.

			Yes	No
Waive the waiting period for present employees enrolling with the group? (YES/NO)				
Waiting Period for future Employees: (Please pick one)	First day of policy Month following:	0 Days		
		30 Days		
		60 Days		
	or immediately after 90 Days			
Waive waiting period for rehires? (YES/NO)				

Employer Eligibility

Full-Time Equivalent Employees

The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H©(2) must be utilized to determine group size for health coverage.

A. FTEs from full-time employees. Number of full-time employees working on average 30 hours or more a week (or 130 hours a month) for more than 120 days a y ear (even if they are not eligible or enrolling for health coverage).	
B. FTEs from part-time employees (excluding seasonal workers). Number of part-time employees who worked on average less than 30 hours a week. (Add up the total number of hours worked in a week by part-time employees and divide by 30. Example, 10 employees working 20 hours a week: 10 x 20 = 200 / 30 = 6.66 = 6 (rounding down to the nearest whole number).	
C. Total number of FTEs = A + B	

Participation Determination

Total number of eligible employees based on state law must work a minimum of 30 hours a week. Note: An employer may not set eligibility rules that would require an employee to work more than 30 hours a week to obtain small group coverage. As long as the employee meets the 30 hour a week standard, they are considered full time for purposes of coverage.

Number of employees eligible for coverage (employees working 30 hours per week)			
Number of employees enrolling		**Number of employees waiving coverage**	
Number of full-time employees excluding union employees		**Number of employees working outside Maryland List all states:**	
Number of part-time employees		**Number of employees not actively at work**	

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Number of 1099 employees		Number of COBRA continuees	
Number of union employees		Number of employees in waiting period and not eligible	

General Information	Yes	No
Cover Part-time (Part-time is defined as more than 17.5 hours and less than 30 hours) Employees?		
Cover Domestic Partners of Employees?		
Cover Employees with Other Coverage?		
Is your employer group required to comply with ERISA? (Most private sector plans are ERISA plans) If no, please indicate appropriate category: ☐ Church ☐ Federal Government ☐ Indian Tribe - Commercial Business ☐ State, Local or Tribal Gov ☐ Foreign Government / Foreign Embassy ☐ Non-ERISA Other		
Is your employer group required to comply with COBRA regulation or State Continuation? (YES/NO)		
Do you have any present or former employees/dependents on COBRA or State Continuation? (YES/NO)		

If yes, please attach list of people with name, qualifying information, date of eligibility and date of coverage termination	

Special Provisions Related to Medical Eligibility

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision described in the Certificate of Coverage for the carrier(s).

Medicare primary versus secondary

How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year? Include: Full-time, part-time, seasonal, temporary, union, owners, partners, officers. Exclude: Self-employed persons, independent contractors 1099), directors. If you employed fewer than 20 employees for 20 weeks in the current or prior year, your group has Medicare as primary. If you employed 20 or more employees for 20 weeks in the current or prior year, your group insurance is primary.	

FRAUD STATEMENT

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CARRIER STATEMENT

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.

PARTICIPATING SHOP CARRIER CORPORATE NAMES AND ADDRESSES

Aetna Health, Inc. 80 Jolly Road Blue Bell, PA 19422 (844) 241-0209	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 (844) 241-0209	CareFirst BlueChoice, Inc. 840 First Street, NE Washington, D.C. 20065 (202) 479-8000	Group Hospitalization and Medical Services, Inc. 840 First Street, NE Washington, D.C. 20065 (202) 479-8000	CareFirst of Maryland, Inc. dba CareFirst BlueCross BlueShield 10455 Mill Run Circle Owings Mills, MD 21117-53559
Dominion Dental Services, Inc. 115 S. Union Street, Suite 300 Alexandria, VA 22314 (703) 518-5000	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 East Jefferson Street Rockville, MD 20852 (800) 777-7904	Optimum Choice, Inc. MAMSI Life and Health Insurance Company 6220 Old Dobbin Lane Columbia, MD 21045 (877) 856-2430	UnitedHealthcare Insurance Company UnitedHealthcare of the Mid-Atlantic, Inc. 6220 Old Dobbin Lane Columbia, MD 21045 (877) 856-2430	

EMPLOYER ATTESTATION AND SIGNATURE

Name of Group			
Officer Signature		Officer Title	
Officer Printed Name		Date	
Officer Email		Officer Phone Number	

Broker Name		Broker ID	
Broker Signature		Date	
Broker Email		Broker Phone Number	
Carrier Name		Carrier ID	
Carrier Representative Signature		Date	
Carrier Email		Carrier Phone Number	

Maryland Health Connection - Maryland SHOP Plans

Broker Information

I certify that I am not aware of any information not disclosed in this application by the client that may have bearing on this risk, for all products being applied for.

I represent that I am licensed and authorized to sell SHOP-eligible products in the State of Maryland.

I certify that I have advised the client not to terminate any existing coverage until receiving written notice from the carriers that the coverage being applied for by this application is accepted.

General Agent	**Broker TAX ID Number**
Broker Name	**Broker Email Address**
Broker Office Number	**Broker Cell Phone Number**
Agency Name	**Pay Commissions to the Agency or the Broker**
Agency Contact	**Broker Fax Number**
Broker Street Address	**City State Zip**
National Producer Number	**License Number**

*Your broker is/may be paid commissions and other financial incentives by any of the participating SHOP insurance carriers.

Maryland Health Connection - Direct Enrollment SHOP Plans

EMPLOYEE ELIGIBILITY AND ELECTION FORM

☐ New Hire/Rehire	☐ Coverage Change	☐ Special Enrollment	☐ Waiver
☐ Information Update	☐ COBRA/State Continuation		☐ Open Enrollment

1. EMPLOYER INFORMATION

Employer Section Only (Include Applicable Effective Dates)

Employer Name:				
Employer Physical Address:				
Employer City:		State:		Zip Code:
Employer Phone Number:		Group Number:		
Group Administrator (Person to Contact):	Contact Phone / Email:	Chief Executive Officer / President:		Contact Phone / Email:
Type of Organization	☐C-Corp ☐ LLC/LLP ☐ Partnership ☐ Sole Proprietorship ☐Non-Profit Other:	Total Number of Full-Time Employees and FTE Employees		Federal Tax Identification Number:
Billing Address (if other than above)		Medical Effective Date:		Dental Effective Date:

2. EMPLOYEE INFORMATION

(If you do not want SHOP coverage from your Employer, complete this section and go to Step 6, Waiver of Coverage)

Last Name:	First Name:	M.I.:	Suffix:	Social Security Number:	
Email Address (Notifications will be sent electronically):			Phone Number ☐H ☐W ☐C		Other Phone Number ☐H ☐W ☐C
Home Address:					Apt or Suite Number:
City:	State:		Zip Code:		County:
Mailing Address (if different from home address):	Apt / Suite #:	City:	State:	Zip Code:	County:
Gender ☐ Female ☐ Male ☐ Other	Date of Birth:		Marital Status:	☐ Single ☐ Married ☐ Divorced ☐Widowed ☐Domestic Partner Date of Marriage:	
Date of Hire/Rehire :	Hours Worked Per Week :		Employment Status: ☐ FT ☐ PT ☐ Other	Occupation:	
Payroll Frequency	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Semi-Monthly	Are you actively at work? ☐Yes ☐No

Race (OPTIONAL – Check all below that apply)			Preferred Spoken or Written Language (If Not English):		
If Hispanic/Latino, ethnicity (OPTIONAL – Check all that apply):	☐Mexican	☐Mexican American	☐ Chicano/a	☐Puerto Rican ☐ Cuban	☐Other
☐Black or African American	☐White	☐Filipino	☐Vietnamese	☐Guamanian or Chamorro	
☐ American Indian/Alaska Native	☐ Asian Indian	☐Other Asian	☐ Chinese	☐Korean	
☐ Other Pacific Islander	☐ Native Hawaiian	☐Samoan	☐ Japanese	☐ Other:	
If you're American Indian or Alaska Native, tell us what state and the name of your federally-recognized tribe					

3. GENERAL INFORMATION (Complete all information)

	Last Name	First Name	M.I.	Date of Birth	Social Security No.	Gender	Tobacco use (Y/N)*	Medical (Y/N)	Dental (Y/N)	Effective Date	Terminati -on Date
Self											
Spouse / DP											

Maryland Health Connection - Direct Enrollment SHOP Plans

EMPLOYEE ELIGIBILITY AND ELECTION FORM

Child											
Child											
Child											
Child											

Primary Care Provider Number and Name		**Current Patient (Y/N)**		**Dentist Provider Code, Name and Number**	**Current Patient (Y/N)**

Are any dependents Disabled?	☐ **Yes**	☐ **No**	**Name(s)**	**Full-Time Student** ☐ **Yes** ☐ **No**	**Name(s)**

* **Tobacco Use: Use of tobacco on average four or more times per week within the past 6 months, excluding religious or ceremonial use of tobacco.**

(School documentation may be required)

4. 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:**	**Termination Date:**	
Who is covered?	☐ **Self** ☐ **SP/DP**	☐ **Child(ren)**	☐ **All**	**Other Carrier(s) 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?	☐ **Yes** ☐ **No**	**Medicare #:**	**Part A Effective Date:**	**Part B Effective Date:**	**Part D Effective Date:**		

5. BENEFIT ELECTION (Indicate election for each benefit offered by your employer.

MEDICAL PLAN

(Benefit Administrator: Highlight the carriers / plans available for enrollment)

Policy:	☐ **Individual**		☐ **Individual & Adult**		☐ **Individual & 1 Child**		☐ **Individual & Children**		☐ **Family**	
Aetna Health, Inc.	☐ Aetna Bronze HMO 5000 80% HSA	☐ Aetna Silver HMO 4500 80%	☐ Aetna Gold HMO 2500 90%	**Aetna Life Insurance Company**	☐ Aetna Bronze PPO 5000 80/60 HSA	☐ Aetna Silver PPO 4500 80/60	☐ Aetna Gold PPO 2500 90/70			
CareFirst BlueChoice, Inc.	☐ BlueChoice HMO 1000 (Gold)	☐ BlueChoice HMO HSA/HRA 2000 (Silver)	☐ BlueChoice HMO Referral HSA/HRA 5500 (Bronze)	**CareFirst of Maryland, Inc.**	☐ BluePreferred PPO 1000 90%/70% (Gold)	☐ BluePreferred PPO HSA/HRA 2000 80%/60% (Silver)	☐ BluePreferred PPO HSA/HRA 5500 (Silver)			
Group Hospitalization and Medical Services,	☐ BluePreferred PPO 1000 90%/70% (Gold)	☐ BluePreferred PPO HSA/HRA 2000 80%/60% (Silver)	☐ BluePreferred PPO HSA/HRA 5500 (Silver)							
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	☐ KP MD Platinum 0/10/Dental	☐ KP MD Platinum 500/20/Dental	☐ KP MD Gold 0/20/Dental	☐ KP MD Gold 1000 / 20 / Dental	☐ KP MD Bronze 6550/0%/HSA/Dental	☐ KP MD Gold 1400/0%/HSA/Dental	☐ KP MD Silver 1700/40/Dental	☐ KP MD Silver 2500/40/Dental	☐ KP MD Silver 1500/30/HSA/Dental	☐ KP MD Silver 2500/30/HSA/Dental
	☐ KP MD Bronze 5500/50/Dental	☐ KP MD Bronze 5750 / 30 / 20% / HSA / Dental	☐ KP MD Bronze 5500/50/POS/Dental							
UnitedHealthcare of the Mid-Atlantic, Inc.	☐ UHC Core Essential HSA HMO Bronze 4000-2	☐ UHC Core Essential HSA HMO Gold 1500-2	☐ UHC Core Essential HSA HMO Bronze 6650-2	☐ UHC Core Essential HSA HMO Silver2250-2	☐ UHC Navigate HSA HMO Gold 2250-2	☐ UHC Navigate HSA HMO Bronze 4000-2	☐ UHC Navigate HSA HMO Bronze 6650-2	☐ UHC Navigate HSA HMO Silver 3500-2	☐ UHC Core Essential HMO Bronze 5250-2	☐ UHC Navigate HMO Bronze 5250-2
	☐ UHC Navigate HMO Silver 2000-1	☐ UHC Navigate HMO Gold 750-1	☐ UHC Core Essential HMO Silver 2000-2	☐ UHC Core Essential HMO Gold 750-2						
UnitedHealthcare Insurance Company	☐ UHC Choice Plus HSA POS Gold 1400-2	☐ UHC Choice Plus HSA POS Gold 1500-2	☐ UHC Choice Plus HSA POS Silver 2250-2	☐ UHC Choice Plus HSA POS Bronze 4000-2	☐ UHC Choice Plus HSA POS Silver 2600-2	☐ UHC Choice Plus POS Platinum 250-6	☐ UHC Choice Plus POS Gold 750-2	☐ UHC Choice Plus POS Silver 2000-2	☐ UHC Choice Plus POS Gold 1500-2	☐ UHC Choice Plus POS Platinum 0-2
	☐ UHC Choice Plus POS Platinum 0-4									

Maryland Health Connection - Direct Enrollment SHOP Plans

EMPLOYEE ELIGIBILITY AND ELECTION FORM

Optimum Choice, Inc.	☐ UHC OCI HSA HMO Bronze 4000-2	☐ UHC OCI HSA HMO Gold 1500-2	☐ UHC OCI HSA HMO Silver 2250-2	☐ UHC OCI HSA HMO Bronze 6650-2	☐ UHC OCI HSA HMO Gold 1400-2	☐ UHC OCI HSA HMO Silver 2600-2	☐ UHC OCI HMO Bronze 5250-2	☐ UHC OCI HMO Silver 2000-2	☐ UHC OCI HMO Gold 750-2	☐ UHC OCI HMO Gold 1500-2
	☐ UHC OCI HMO Platinum 0-2	☐ UHC OCI HMO Platinum 0-4	☐ UHC OCI HMO Platinum 0-6							
MAMSI Life and Health Company	☐ UHC Choice HSA EPO Bronze 4000-2	☐ UHC Choice HSA EPO Bronze 6650-2	☐ UHC Choice HSA EPO Gold 1400-2	☐ UHC Choice HSA EPO Gold 1500-2	☐ UHC Choice HSA EPO Silver 2250-2	☐ UHC Choice HSA EPO Gold 1400-4	☐ UHC Choice HSA EPO Silver 2600-2	☐ UHC Choice EPO Platinum 250-2	☐ UHC Choice EPO Bronze 5250-2	☐ UHC Choice EPO Silver 2000-2
	☐ UHC Choice EPO Gold 1500-2	☐ UHC Choice EPO Platinum 0-2	☐ UHC Choice EPO Platinum 0-4	☐ UHC Choice Plus POS Platinum 0-2						
Dental Enrollment	☐ **Individual**		☐ **Individual & 1 Child**		☐ **Individual & Children**		☐ **Family**			

6. WAIVER OF COVERAGE

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 "Waive" 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. Enrollment must be requested within the time limit for the specific qualifying event (30-60 days) as described in § 15-1208.1(e), 15-1208.2(d)(2) and (9) of the Insurance Article and 45 CFR § 155.726(c)(3).

☐ **No I do not want health coverage from this employer.** If this employer offers health coverage for my dependents, I decline that offer of coverage, too.

Do you have another source of health coverage?	☐**Yes**	☐**No**	
(If YES, what type?	☐ Individual private health insurance	☐ Insurance from another job	☐ Insurance through another person's job
☐ Medicare	☐ Medicaid	☐ Indian Health Service	
☐ TRICARE		☐ VA Health Care Programs	☐ Other

☐ **If this employer offers dental coverage, I do not want that coverage. If this employer offers dental coverage for my dependents, I decline that offer, too.**

Signature:		**Date:**	

7. SPECIAL ENROLLMENT AND QUALIFYING EVENT INFORMATION FOR BENEFIT AND COVERAGE CHANGES:

The SHOP must provide special enrollment periods consistent with the section 45 CFR 155.726 and 45 CFR 155.420.

Please provide details below and corresponding documentation regarding the Qualifying Event:						**Date of Event:**	
Type of Event:	☐ **Involuntary loss of other MEC coverage**	☐ **Marriage**	☐ **Divorce**	☐ **Birth or Adoption**	☐ **Death**	☐ **Loss of Medicaid coverage**	☐ **Medicaid Determination Error**
☐ **Gaining other coverage**	☐ **Permanent Move with Access to new QHPs**			☐ **Material Contract Violation**	☐ **Exchange Error**	☐ **Other**	

☐ **Terminate Coverage for Self, Spouse and/or Dependent(s) (including due new eligibility for Medicaid or MCHP)**	☐ **Domestic Abuse/Spousal Abandonment [defined by 26 CFR 1.36B-2T]**
☐ **Add Coverage for Self, Spouse and/or Dependent(s)**	**Additional Details:**
Coverage Change:	**Additional Details:**

Please Note: Enrollment must be requested within the time limit for the specific qualifying event (30-60 days) as described in § 15-1208.1(e), 15-1208.2(d)(2) and (9) of the Insurance Article and 45 CFR § 155.726(c)(3).

8. 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact your employer before signing this election form.

EMPLOYEE SIGNATURE :		**Date:**	
EMPLOYER SIGNATURE/VERIFICATION :		**Date:**	

Maryland Health Connection - Direct Enrollment SHOP Plans

EMPLOYEE ELIGIBILITY AND ELECTION FORM

9. PARTICIPATING SHOP CARRIER CORPORATE NAMES AND ADDRESSES

Aetna Health, Inc. **80 Jolly Road** **Blue Bell, PA 19422** **(844) 241-0209**	**Aetna Life Insurance Company** **151 Farmington Avenue** **Hartford, CT 06156** **(800) 872-3862**	**CareFirst BlueChoice, Inc.** **840 First Street, NE** **Washington, D.C. 20065** **(202) 479-8000**	**Group Hospitalization and Medical Services, Inc.** **840 First Street, NE** **Washington, D.C. 20065** **(202) 479-8000**	**CareFirst of Maryland, Inc.** **dba CareFirst BlueCross BlueShield** **10455 Mill Run Circle** **Owings Mills, MD 21117** **(410) 581-3000**
Dominion Dental Services, Inc. **115 S. Union Street, Suite 300** **Alexandria, VA 22314** **(703) 518-5000**	**Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.** **2101 East Jefferson Street** **Rockville, MD 20852** **(800) 777-7904**	**Optimum Choice, Inc., MAMSI Life and Health Insurance Company, United Healthcare Insurance Company and United Healthcare of the Mid-Atlantic, Inc.** **6220 Old Dobbin Lane** **Columbia, MD 21045** **(877) 856-2430**		

ACH Authorization Form

I, _____ hereby authorize BenefitMall Auto Billing, Company ID #1592022495, to initiate ACH (Automatic Clearing House) fund transfers from my financial institution listed below and if necessary, initiate adjustments for any transactions credited/debited in error. If a transaction is returned for insufficient funds, a $35.00 fee will be assessed for each attempt. This authority will remain in effect until BenefitMall is notified by me, in writing, to cancel it in such time as to afford BenefitMall a reasonable opportunity to act on it.

The purpose of these funds is to pay my group insurance coverages. The monthly transfer of funds will be deducted from my account on the day specified below (adjusting for weekends and holidays) for that month's coverage.

Group Name: _____

Address: _____

City/State/Zip: _____

Email Address: _____

Effective Month for ACH Debit: _____

Day to transfer: 1st _____ 7th _____

BenefitMall Group #: _____ Division(s) #: _____ or All_____

Name of Financial Institution: _____

Financial Institution Routing Number: _____

Checking/Savings Account Number: _____

Please email this completed form, a copy of a voided check (if available), to BMS@BenefitMall.com **or mail to:**

501 Fairmount Avenue, Suite 400
Towson, MD 21286
Attention Accounts Receivables

Name: _____ Signature: _____
(Please Print)

Date: _____ Company & Authority: _____