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											

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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									

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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:**	

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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**		