CRC BENEFITS

P.O. Box 42827 Baltimore, MD 21284-2827
Fax: (410) 512-3984

EMPLOYEE ELECTION FORM

THIS IS NOT AN APPLICATION FOR INSURANCE

CRC Billing # _____
Effective Date _____
Division # _____
Employer with 20 or more employees? ☐ **Yes** ☐ **No**

☐ New Hire ☐ Re-Hire ☐ COBRA/Continuation (Group Administered) ☐ Add Coverage

Last Name	**First Name**	**M.I.**	**Employer**

Street Address	**Social Security Number**

City	**State**	**Zip**	**Gender** ☐ **Male** ☐ **Female**	**Date of Birth**

Home Telephone #	**Business Telephone #**	**Marital Status** ☐ **S** ☐ **M** ☐ **D** ☐ **W**	**Date of Marriage**	**Full-Time/Re-Hire Employment Date:**

Employee Email	**Payroll Mode (weekly, bi-weekly, etc)**

Are you actively working for the employer listed above (as defined in your insurance contract)? ☐ **Yes** ☐ **No** ☐ **Full-time** ☐ **Part-time**	**Hours Worked/Week**

Occupation	Employee Class	**Annual Salary/Hourly Wage**

MEDICAL PLAN[1]
Carrier _____
Carrier Group # _____
Plan Type _____

☐ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ **Waive Coverage***

DENTAL PLAN
Carrier _____
Carrier Group # _____
Plan Type _____

☐ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ **Waive Coverage***
**** If enrolling in a DHMO dental plan, please complete provider information below.**

VISION PLAN
Carrier _____
Carrier Group # _____
☐ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ **Waive Coverage***

☐ **LTD** ☐ **Waive Coverage***
☐ **VOL. LTD** ☐ **Waive Coverage***
Carrier _____
Benefit $ _____/Mo

☐ **LIFE AND AD&D**
☐ **Waive Coverage***
☐ **VOL LIFE $** _____
☐ **SPOUSE $** _____
☐ **DEP. CHILD $** _____
Carrier _____

☐ **STD** ☐ **Waive Coverage***
☐ **VOL. STD** ☐ **Waive Coverage***
Plan # _____
Benefit $ _____/ Wk.
Carrier _____

***Waiver of Coverage: I certify that group insurance coverage has been offered to me and I choose to waive coverage due to:**
☐ Spousal/Partner Coverage ☐ Parent Coverage ☐ Individual Coverage on Exchange ☐ Individual Coverage off Exchange ☐ Military/VA Coverage ☐ Retiree Coverage ☐ COBRA/Continuation ☐ Medicare/Medicaid ☐ No Coverage ☐ Other _____

Life Insurance Beneficiary **Relationship**

Last, Full First, M.I.	**Social Security Number**	**Birth Date**	**Sex**	**Stu-dent (Y/N)**	**Dis-abled (Y/N)**	****For HMO, POS, Opt-Out and Dental (if offered) Plans: Primary Care Provider Name and Carrier Assigned Provider #**	**Existing Patient (Y/N)**
Emp							
Sp							
Chd							
Chd							
Chd							

OTHER/PRIOR HEALTH INSURANCE: Please note: You must complete this section if waiving or enrolling in medical coverage and your company offers Dual Coverage OR if you are currently covered under Medicare.
Do you or your dependents have other/prior Health coverage with another insurer? ☐No ☐ Yes Dental? ☐No ☐ Yes *If Yes*: Effective Date:_____
☐Other ☐ Prior (indicate one or both) Carrier Name_____Policy #_____
Will this coverage be continued? ☐ Yes ☐ No *If No*: Term. Date: _____
Are you covered by Medicare? ☐No ☐ Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__ Medicare #_____
Is your spouse or dependent(s) covered by Medicare?☐ No ☐ Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__
Name of spouse or dependent(s) covered (if applicable): _____ Medicare #_____

CERTIFICATION: I hereby certify that I am the spouse, parent or legal guardian of the dependent(s) shown above. ***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.***

- **Voluntary benefits may be subject to pre-existing condition exclusions (please refer to your policy for more information).**

I authorize my employer to make any necessary payroll deductions and also declare that any disability coverage in force and applied for, with respect to myself, is less than 75% of my current monthly earnings (60% for intermediate disability income). I have read and acknowledge all statements under the Acknowledgement section of Page 2 of this Election Form.

EMPLOYEE SIGNATURE _____ **DATE**_____

EMPLOYER SIGNATURE/VERIFICATION_____ **DATE**_____

Acknowledgements

If you have any questions concerning the benefits and services provided by or excluded under this agreement or the acknowledgements listed below, please contact your licensed broker before signing this enrollment card.

HIPAA
I acknowledge and agree that any personally identifiable heath information about me on my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPPA) and other privacy laws, and that, in accordance with those laws, the carrier may use and disclose Protected Information for payment, treatment and health care operations as described by their Notice of Privacy Practices. I understand that a copy of the carrier Notice of Privacy Practices may be obtained on their websites or by calling the customer service number on the back of the identification card.

Fraud
To the best of my knowledge and belief, the information provided on the attached application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Medical- Notice of Special Enrollment Period

By declining enrollment for myself or my dependent(s) (including your spouse) because of other health insurance coverage, I understand I may not be able to enroll myself or my dependent(s) in this plan in the future, provided that I request enrollment within 30 days of the termination date of your prior coverage. And that by declining enrollment for myself or my dependent(s) because of other health insurance coverage I must complete the section titled ***"Other Health Insurance"*** on the Election Form to preserve my future enrollment rights.

I understand if I decline coverage for myself or a dependent(s) because of other health coverage and do not complete the ***"Other Health Insurance"*** section on the Election Form (or provide written proof from the other plan), or do not request enrollment in within 30 days after my (and/or) dependents' other coverage ends, I will not be eligible to enroll myself or my dependent(s) during the enrollment period discussed above. I will then need to wait until the next open enrollment period (if applicable) to enroll in the plan's health coverage.

I understand if I am currently declining coverage for myself or my dependent(s), I can enroll myself and/or my dependent(s) at a later date in accordance with the following special enrollment provisions:

- **I and/or my dependent(s) are no longer eligible under my spouse's coverage:**
  - because my spouse's employment or his/her group had been terminated;
  - by divorce from your spouse; or
  - due to the death of your spouse.
- **I am no longer eligible under your parent's coverage.**
- **I and/or my dependent(s) have coverage through another group but later become ineligible for coverage through the group (including COBRA participants).**
- **My group health plan may also allow employees who are already enrolled for coverage to add dependents upon marriage, birth, adoption, and placement for adoption.**

Please contact your Group Administrator for more detailed information on your group's Special Enrollment Provisions.

Non-Medical

I understand if I am voluntarily declining the non-medical coverage provided by my employer, I may choose to enroll at a later date depending upon the availability of coverage, which is now being waived.

Life/Disability: if I waived life or disability and later decide to enroll, the carrier may require me to provide, at my own expense, proof of insurability. Late enrollment may cause an increase in cost and submission of a health questionnaire. Carriers reserve the right to reject late entrant requests.

Dental: if I waived dental coverage and later decide to enroll, I may be subject to a late entrant penalty and my dental benefits may be limited for a period of time. The carrier may waive late entrant penalties if I lose coverage due to a termination of the plan, loss of employment, death of a spouse or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided I apply within 30 days of the lifestyle change.

(1) HMO Plan Selection (applicable to all medical carriers who offer HMO coverage)