# Maryland Health Connection for Small Business - 2022 Direct Enrollment

## 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 this 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) |
|---|---|---|---|---|---|---|---|---|---|
| Self | | | | | | | | | |

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| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Spouse / DP | | | | | | | | |
| 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): (School documentation may be required) |

| | | |
|---|---|---|
| *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. | Yes ☐ | No ☐ |

## 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 HNOption 8000 70/50 INT | ☐ Aetna Silver HMO 3500 100% HSA T | ☐ Aetna Gold HMO 1000 100% E Value | Aetna Life Insurance Company | ☐ Aetna Bronze PPO 7500 70/50 INT Value | ☐ Aetna Gold OAEPO 1500 80% | ☐ Aetna Silver OAEPO 2500 100% Value | | | |
| CareFirst BlueChoice, Inc. | ☐ BlueChoice HMO 1000 (Gold) | ☐ BlueChoice HMO HSA/HRA 2400 (Silver) | ☐ BlueChoice HMO Referral HSA/HRA 6200 (Bronze) | ☐ BlueChoice HMO Gold 1500 | ☐ BlueChoice HMO HSA/HRA Bronze 6100 | ☐ BlueChoice HMO HSA/HRA Silver 1500 | ☐ BlueChoice HMO HSA/HRA Silver 3000 | ☐ BlueChoice HMO Silver 5000 | ☐ BlueChoice HMO Value Bronze 6000 | ☐ BlueChoice HMO Referral Bronze 8250 |
| | ☐ BlueChoice Advantage Gold 1000 | ☐ BlueChoice Advantage HSA/ HRA Bronze 6100 | ☐ BlueChoice Advantage HSA/ HRA Silver 3000 | ☐ BlueChoice Advantage HSA/ HRA Gold 1500 | ☐ BlueChoice Advantage Silver 5000 | | | | | |
| Group Hospitalization and Medical Services, Inc. | ☐ BluePreferred PPO HSA/HRA 6200 (Bronze) | ☐ BluePreferred PPO 1000 90%/70% (Gold) | ☐ BluePreferred PPO HSA/HRA 2400 80%/60% (Silver) | CareFirst of Maryland, Inc. | ☐ BluePreferred PPO HSA/HRA 6200 (Bronze) | ☐ BluePreferred PPO 1000 90%/70% (Gold) | ☐ BluePreferred PPO HSA/HRA 2400 80%/60% (Silver) | | | |
| Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. | ☐ KP MD Platinum 0/10/ Vision | ☐ KP MD Platinum 500/20/Vision | ☐ KP MD Gold 0/20/Vision | ☐ KP MD Gold 1000/20/Vision | ☐ KP MD Gold Virtual Forward 2000 | ☐ KP MD Gold 1400/0%/HSA/ Vision | ☐ KP MD Bronze 6850/0%/HSA/ Vision | ☐ KP MD Silver 1850/40/Vision | ☐ KP MD Silver 2500/40/Vision | ☐ KP MD Silver Virtual Forward 3000 |
| | ☐ KP MD Silver 2000/30/HSA/ Vision | ☐ KP MD Bronze 6150/30/HSA/ Vision | ☐ KP MD Bronze 6500/50/Vision | | | | | | | |
| UnitedHealthcare of the Mid-Atlantic, Inc. | ☐ UHC Core Essential HSA Bronze 7000-2 | ☐ UHC Core Essential HSA Gold 2250-2 | ☐ UHC Navigate HSA Bronze 7000-2 | ☐ UHC Navigate HSA Gold 1600-2 | ☐ UHC Core Essential HSA Silver 2500-2 | ☐ UHC Navigate HSA Silver 2500-2 | ☐ UHC Core Essential Gold 750-2 | ☐ UHC Core Essential Silver 3500-2 | ☐ UHC Navigate Gold 750-2 | ☐ UHC Navigate Silver 3500-2 |
| UnitedHealthcare Insurance Company | ☐ UHC Choice Plus HSA Bronze 7000-2 | ☐ UHC Choice Plus HSA Gold 1600-6 | ☐ UHC Choice Plus HSA Silver 2500-2 | ☐ UHC Choice Plus Gold 750-2 | ☐ UHC Choice Plus Gold 1500-4 | ☐ UHC Choice Plus Silver 5000-3 | ☐ UHC Choice Plus Silver 3500-2 | ☐ UHC Choice Plus Platinum 0-4 | | |
| Optimum Choice, Inc. | ☐ UHC OCI HSA Bronze 7000-2 | ☐ UHC OCI HSA Gold 2250-2 | ☐ UHC OCI HSA Silver 2500-2 | ☐ UHC OCI Gold 3500-2 | ☐ UHC OCI Gold 750-2 | ☐ UHC OCI Gold 1500-3 | ☐ UHC OCI Silver 5000-3 | ☐ UHC OCI Silver 2000-2 | ☐ UHC OCI Platinum 0-2 | ☐ UHC OCI Platinum 0-4 |

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| MAMSI Life and Health Company | ☐ UHC Choice HSA Bronze 7000-2 | ☐ UHC Choice HSA Gold 1600-2 | ☐ UHC Choice HSA Gold 2250-2 | ☐ UHC Choice HSA Silver 2500-2 | ☐ UHC Choice Gold 1500-2 | ☐ UHC Choice Platinum 0-2 | ☐ UHC Choice Platinum 0-4 | ☐ UHC Choice Gold 1500-4 | ☐ UHC Choice Silver 5000-4 | ☐ UHC Choice Silver 3500-2 |
|---|---|---|---|---|---|---|---|---|---|---|
| | ☐ UHC Choice Plus Platinum 0-2 | | | | | | | | | |

## 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:

**MHBE 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** |

| ☐ **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. 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.

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:** | |