maryland health connection for small business

(Carrier Use Only)
Group Number:

Maryland Health Connection for Small Business - 2025 Direct Enrollment
EMPLOYEE ELIGIBILITY AND ELECTION FORM

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

1. EMPLOYER INFORMATION
Employer Section Only (Include Applicable Effective Dates)

Employer Name:			
Employer Physical Address:			
Employer City:	State:	Zip Code:	
Group Administrator (Person to Contact):	Contact Phone / Email:	Chief Executive Officer / President:	Contact Phone / Email:
Billing Address (if other than above)	Medical 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 ☐	Phone Number: H ☐ W ☐ C ☐	
Home Address:				Apt #:	
City:	State:		Zip Code:	County:	
Mailing Address (if different from home address):	Apt #:	City: State:	Zip Code:	County:	
Gender: ☐ Female ☐ Male ☐ Other	Date of Birth:	Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Married (Date of Marriage _____)			
Date of Hire/Rehire:	Hours Worked Per Week:	Employment Status: ☐ FT ☐ PT ☐ Other		Occupation:	

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:				

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3. GENERAL INFORMATION (Complete all information)

	Last Name	First Name	M.I.	Date of Birth	Social Security No.	Gender	Full-time Student (Y/N)	Disabled (Y/N)
Self								
Spouse/ DP								
Child								
Child								
Child								
Child								
Child								

Primary Care Provider Name:		Primary Care Provider NPN:		Current Patient: Yes ☐ No ☐

4. OTHER HEALTH INSURANCE COVERAGE INFORMATION (Failure to complete this section may result in claims denial)

Do you or your dependents described on this form have "health" coverage with another insurer? Yes ☐ No ☐

If yes, Policy Effective Date: _____

Policy Termination Date: _____

Who is covered? ☐ Self ☐ Spouse ☐ Dependent/s

Will you or your dependents continue coverage with other insurer(s)?

Yes ☐ No ☐

Other coverage is through: ☐ Individual Policy ☐ Spouse's Employer

Other Carrier(s) Name: _____ Policy #: _____

Are you covered by Medicare? Yes ☐ No ☐

Medicare Policy #: _____

Part A Effective Date:_____ Part B Effective Date:

Part D Effective Date: _____ _____

5. WAIVER OF COVERAGE/CANCELLATION

I hereby certify that the benefits provided by my Employer have been explained to me, that I have been allowed 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).

☐ **This employee has been terminated and coverage should be canceled/terminated.**
(Select this option if the employee is no longer employed and has coverage that requires termination.)

☐ **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 ☐

☐ Individual private health insurance ☐ Insurance from another job ☐ Insurance through another person's job

☐ Medicare ☐ Medicaid ☐ VA Health Care Programs ☐ Indian Health Service ☐ TRICARE ☐ Other

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

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6. PLAN SELECTION

MEDICAL PLAN CHOICES

Aetna Health, Inc.	☐ Aetna Gold HMO 1000 100% E	☐ Aetna Silver HMO 3500 100% HSA T	☐ Aetna Bronze HNOption 8000 70/50 INT	**Aetna Life Insurance Company**	☐ Aetna Gold OAEPO 1500 80%	☐ Aetna Silver OAEPO 2500 100%	☐ Aetna Bronze PPO 7600 70/50 INT
CareFirst BlueChoice, Inc.	☐ BlueChoice Advantage Gold 1000 Ded	☐ BlueChoice Advantage HSA/ HRA Gold 1700 Ded	☐ BlueChoice HMO Gold 1500 Ded	☐ BlueChoice HMO HSA/HRA Silver 1950 Ded	☐ BlueChoice HMO HSA/HRA Silver 2900 Ded	☐ BlueChoice HMO Silver 6500 Ded	
	☐ BlueChoice HMO Bronze 6000 Ded	☐ BlueChoice Advantage HSA/ HRA Bronze 6100 Ded	☐ BlueChoice HMO Referral HSA/HRA Bronze 6200 Ded				
Group Hospitalization and Medical Services, Inc.	☐ BluePreferred PPO Gold 1250 Ded	☐ BluePreferred PPO HSA/HRA Silver 2900 Ded	☐ BluePreferred PPO HSA/HRA Bronze 6200 Ded	**CareFirst of Maryland, Inc.**	☐ BluePreferred PPO Gold 1250 Ded	☐ BluePreferred PPO HSA/HRA Silver 2900 Ded	☐ BluePreferred PPO HSA/HRA Bronze 6200 Ded
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	☐ KP MD Platinum 0 Ded/Vision	☐ KP MD Platinum 500 Ded/Vision	☐ KP MD Gold 0 Ded/Vision	☐ KP MD Gold 1000 Ded/100 RxDed/Vision	☐ KP MD Gold Virtual Complete 2000 Ded	☐ KP MD Gold 1650 Ded/HSA/Vision	☐ KP MD Silver 2000 Ded/HSA/ Vision
	☐ KP MD Silver 1800 Ded/350 RxDed/Vision	☐ KP MD Silver 2500 Ded/Vision	☐ KP MD Silver Virtual Forward 3000 Ded	☐ KP MD Bronze 7000 Ded/HSA/ Vision	☐ KP MD Bronze 6150 Ded/HSA/ Vision	☐ KP MD Bronze 6500 Ded/Vision	
UnitedHealthcare of the Mid-Atlantic, Inc.	☐ UHC Core Essential Gold 750-2	☐ UHC Core Essential HSA Gold 1850-2	☐ UHC Core Essential HSA Silver 2700-2	☐ UHC Core Essential HSA Bronze 7100-2			
UnitedHealthcare Insurance Company	☐ UHC Choice Plus Platinum 0-7	☐ UHC Choice Plus HSA Gold 1800-2	☐ UHC Choice Plus Gold 750-2	☐ UHC Choice Plus HSA Silver 2700- 2	☐ UHC Choice Plus Silver 3800-2	☐ UHC Choice Plus Silver 5250-3	☐ UHC Choice Plus HSA Bronze 7100-2
Optimum Choice, Inc.	☐ UHC OCI Platinum 0-2	☐ UHC OCI Platinum 750-2	☐ UHC OCI Gold 750-2	☐ UHC OCI HSA Gold 2600-2	☐ UHC OCI HSA Silver 2700-2	☐ UHC OCI HSA Bronze 7100-2	
MAMSI Life and Health Company	☐ UHC Choice HSA Bronze 7100-2	☐ UHC Choice HSA Gold 1850-2	☐ UHC Choice HSA Silver 2700-2	☐ UHC Choice Gold 1600-4	☐ UHC Choice Silver 3800-2	☐ UHC Choice Platinum 0-4	☐ UHC Choice Plus Platinum 0-2

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

MHBE must provide special enrollment periods consistent with the sections 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 to 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: (Name of new plan)							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 the terms and conditions of the contract between the carrier and my employer. I agree to pay current and future charges for the coverage provided more than 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 insurance application 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, or 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:**	