

**MBN Benefits Enrollment Form**

| GENERAL INFORMATION  |  |                   |                |                         |               |  |  |
|----------------------|--|-------------------|----------------|-------------------------|---------------|--|--|
| EMPLOYEE NAME (Last) |  | (First)           | (M.I.)         | BIRTH DATE (MM/DD/CCYY) |               | SOCIAL SECURITY NO.  |  |
| HOME PHONE<br>( )    |  | WORK PHONE<br>( ) | E-MAIL ADDRESS |                         | GENDER<br>M F | MARITAL STATUS<br><input type="checkbox"/> Single <input type="checkbox"/> Married<br><input type="checkbox"/> Separated <input type="checkbox"/> Divorced<br>Date of Marriage _____ |  |
| ADDRESS (Street)     |  |                   | (City)         | (State)                 | (Zip Code)    |  |  |

| EMPLOYEE & FAMILY INFORMATION                                     |  |  |                               |                         |                          |   |  |                          |
|---|--|--|-------------------------------|-------------------------|--------------------------|---|--|--------------------------|
| FAMILY INFORMATION<br>(Specify last name if different from yours) |  |  | DEPENDENT SOCIAL SECURITY NO. | INDICATE SPOUSE / CHILD | DATE OF BIRTH MM/DD/CCYY | GENDER M F  | COVERAGE ELECTED<br>Medical Dental Vision                                  | DISABLED                 |
| SPOUSE  |  |  |                               |                         |                          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> |
| DEPENDENT   |  |  |                               |                         |                          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> |
| DEPENDENT   |  |  |                               |                         |                          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> |
| DEPENDENT   |  |  |                               |                         |                          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> |
| DEPENDENT   |  |  |                               |                         |                          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> |
| DEPENDENT   |  |  |                               |                         |                          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> |

| MEDICAL/Rx, DENTAL & VISION COVERAGE<br>with biweekly employee paycheck contribution amounts |  |                                       |                                       | SUPPLEMENTAL EMPLOYEE & SPOUSE LIFE/AD&D<br>Additional Documents and Information will Be Required   |  |
|--|--|---------------------------------------|---------------------------------------|---|--|
| Plans  | EE Only                                | EE + One                              | EE + Family                           | Indicate <i>only new or changed</i> coverage amounts in \$  |  |
| BlueChoice Advantage (\$1000 deductible)   | <input type="checkbox"/> \$ 59.48      | <input type="checkbox"/> \$ 118.97    | <input type="checkbox"/> \$ 163.57    | Employee Supplemental Life/AD&D<br>(max 5X annual earnings, not to exceed \$500K)<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No | Spouse Supplemental Life/AD&D<br>(\$250K max- not to exceed employee amount)<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Signature Advantage PPO (\$500 deductible)   | <input type="checkbox"/> \$ 88.41      | <input type="checkbox"/> \$ 176.82    | <input type="checkbox"/> \$ 243.12    |   |  |
| BlueChoice Advantage (\$0 deductible)  | <input type="checkbox"/> \$ 126.02     | <input type="checkbox"/> \$ 252.04    | <input type="checkbox"/> \$ 346.56    |   |  |
| BlueDental Plus PPO  | <input type="checkbox"/> \$ 6.02       | <input type="checkbox"/> \$ 12.05     | <input type="checkbox"/> \$ 16.87     |   |  |
| CareFirst Blue Vision  | <input type="checkbox"/> \$ 0.00       | <input type="checkbox"/> \$ 0.00      | <input type="checkbox"/> \$ 0.00      | Evidence of Insurability (EOI) is required for any new or increased coverage amounts unless enrolling within 31 days of your hire date            |  |
|  | <input type="checkbox"/> Waive Medical | <input type="checkbox"/> Waive Dental | <input type="checkbox"/> Waive Vision |   |  |

**OTHER INSURANCE INFORMATION (you must complete this section, or claims may be denied):**

Do you or your dependents listed on this form have "health" coverage with another insurer?  Yes  No  
 Effective Date: \_\_\_\_\_ Term. Date: \_\_\_\_\_  
 Who is covered?  Self  Spouse  All  
 Other Carrier 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:  No  Yes Effective Date (Part A) \_\_\_\_\_ / \_\_\_\_\_ (Part B) \_\_\_\_\_ / \_\_\_\_\_  
 Medicare # \_\_\_\_\_

| LIFE BENEFICIARY INFORMATION: |              |            |
|-------------------------------|--------------|------------|
| Beneficiary Name              | Relationship | Percentage |
| Primary:                      |              |            |
| Secondary:                    |              |            |

**SIGNATURE OF EMPLOYEE ACCEPTANCE & PAYROLL AUTHORIZATION**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_