



BenefitMallSM

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10540 York Road P.O. Box 8039, Cockeysville, MD 21030

Form

To: MARGARET CARVELLA
J R MCDONALD, INC.
9690 Deereco Road Ste.410
Lutherville Timonium, MD 21093

Recipient's Fax: - -
Date: June 4, 2004

From: Form

Subject: Your Selected Form

Thank you for using the BenefitMall Online Forms Library.

The following form is attached:

Maryland -> Miscellaneous Forms -> Employee Election Form

If you have problems retrieving your forms, please contact our Customer Service Department at (800)350-0500



BenefitMall

10540 York Road
P.O. Box 8039
Cockeysville, MD 21030

BMLL Billing # _____

Effective Date _____

Team # _____

Carrier Group # (See Coverage Boxes)

EMPLOYEE ELECTION FORM

THIS IS NOT AN APPLICATION FOR INSURANCE

Last Name		First Name		M.I.	Employer	
Street Address					Social Security Number	
City			State	Zip	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Home Telephone # () ()	Business Telephone # () ()	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		Date of Marriage		Date of Full-Time Hire
Are you now actively at work on a full-time basis for this employer (as defined in your insurance contract)? <input type="checkbox"/> Yes <input type="checkbox"/> No					Hours Worked/Week	
Occupation				Class	Annual Salary	

Life Insurance Beneficiary (if coverage offered)			Relationship		
MEDICAL PLAN (if offered) ++ Carrier _____ Plan Type _____ Carrier Group # _____ <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & One Child <input type="checkbox"/> Family <input type="checkbox"/> Over 65 & Retired <input type="checkbox"/> Over 65 & Working <input type="checkbox"/> Waive Coverage*	DENTAL PLAN (if offered) Carrier _____ Plan Type _____ Carrier Group # _____ <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & One Child <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage* Family Dentist** Name _____ Office # _____	VISION PLAN (if offered) Carrier _____ Carrier Group # _____ <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & One Child <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage* LTD (if offered) <input type="checkbox"/> Waive Coverage* VOL. LTD Carrier _____ Benefit \$ _____/Mo.	<input type="checkbox"/> LIFE AND AD&D (if offered) <input type="checkbox"/> Waive Coverage* <input type="checkbox"/> SUPP. LIFE \$ _____ <input type="checkbox"/> SPOUSE \$ _____ <input type="checkbox"/> DEP. CHILD \$ _____ Carrier _____ <input type="checkbox"/> STD (if offered) <input type="checkbox"/> Waive Coverage* <input type="checkbox"/> VOL. STD Plan # _____ Benefit \$ _____/ Wk. Carrier _____		

++If enrolling in HMO coverage, please see message on reverse of this form. *If I have waived any of the coverages offered by my employer as noted above, I attest that I have read the "Waiver of Insurance Coverage" information as outlined on the reverse side of this form.

**Dependent dentist #'s if different from above:

Last,	Full First,	M.I.	Social Security Number	Birth Date	Sex	Stu- dent (Y/N)	Dis- abled (Y/N)	For HMO & POS Plans: Primary Care Provider & # OBGyn Provider & # (if required)	Existing Patient (Y/N)
Emp									
Sp									
Chd									
Chd									
Chd									

MANDATORY --- OTHER HEALTH INSURANCE INFORMATION: Please note: You must complete this section even if medical coverage is waived.

Do you/dependents have "health" coverage with another insurer? Yes No If Yes: Effective Date: _____

Who is covered? Self Spouse Family Other carrier name/policy # _____

Will this coverage be continued? Yes No If No: Term. Date: _____

Are you covered by Medicare? Yes No:

Are any of your dependents covered by Medicare? Yes No: Effective Date (Part A) ___/___/___ Effective Date (Part B) ___/___/___ Medicare # _____

CERTIFICATION: I hereby certify that I am the spouse, parent or legal guardian of the dependents shown above. *I understand that knowingly filing a statement of claim and/or application containing any materially false information, intentionally or unintentionally, or concealing information pertaining to any fact or material with intent to mislead or defraud the insurer constitutes insurance fraud, which is a crime.*

- Voluntary benefits may be subject to a pre-existing condition exclusion (please refer to your policy).

I authorize my employer to make any payroll deductions which may be necessary. I hereby represent 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).

EMPLOYEE SIGNATURE _____ DATE _____

EMPLOYER SIGNATURE/VERIFICATION _____ DATE _____

We currently employ 20 or more full- and part-time people Yes No

WAIVER OF INSURANCE COVERAGE

Medical – Notice of Special Enrollment Period

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you decline enrollment for yourself or your dependents because of other health insurance coverage, you must complete the section titled “other health insurance coverage” on the front of this form in order to preserve your special enrollment rights in the future. If you are declining coverage for yourself or your dependents for any other reason, you cannot join the Plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or during open enrollment period, if applicable. You may then be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you decline coverage for yourself or a dependent because of other health coverage and you fail to fill out the “other health insurance coverage” section on the front of this form (or provide written proof from the other plan) or if you fail to request plan enrollment within 30 days after your (and/or dependent’s) other coverage ends, you will not be eligible to enroll yourself or your dependents during the special enrollment period discussed above and you will need to wait until the next open enrollment period (if available) to enroll in the plan’s health coverage.

Non - Medical

If you are voluntarily declining the non-medical coverages provided by your employer you may choose to enroll at a later date depending upon the availability of coverage which is now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and/or the effective date of your coverage may be delayed.

IMPORTANT MESSAGE FOR HMO MEMBERS

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this enrollment card.