BENEFIT DESIGN GROUP, INC
600 Washington Avenue, Suite 104 : Towson, MD 21204
410-494-0010 or 800-741-4234 phone : 410- 494-0456 fax
www.bdgmd.com : enrollment@bdgmd.com

BDG USE
Date Rec'd:______________
Carrier:________________
BDG:__________________

EMPLOYEE ELECTION FORM THIS IS NOT AN APPLICATION FOR INSURANCE

☐ *New Enrollee* ☐ *Coverage Change* ☐ *Add/Delete Dependents* ☐ *Termination* ☐ *Direct Bill COBRA*

Employer: ___________________________________Customer #: __________Phone #: _________________ Requested Effective Date __________

Employee Name____
Last First M.I.

Social Security #_____________________________________

Address____

Sex M / F Birth Date______________________________

Home Phone____

City____________________________ST__________Zip_____________

Marital Status S/M/D/W_____________(Date of Marital Change)

Full-Time Hire Date____________________ Hours worked/wk________

E-Mail Address ____

Are you actively at work on a full-time basis for this employer? ☐ Yes ☐ No

TO BE COMPLETED ONLY IF APPLYING FOR LIFE/AD&D, STD OR LTD COVERAGE

Occupation____

Class________________ Annual Salary__________________

Primary Beneficiary_____________________________ % _____

Relationship____

Contingent Beneficiary___________________________ % _____

Relationship____

Last First M.I.	Soc. Sec. No.	Birth Date	M/F	Primary Care Physician or Med. Center Name	PCP or MC ID #	Existing Patient (Y/N)	Disabled (Y/N)	Student (Y/N)
Emp								
Sp								
Ch								
Ch								
Ch								

PARTICIPATING DENTIST NAME: ____ PROVIDER CODE: _____________

Medicare: Y ______ N ______ Date (Part A) ____/____/_____ Date (Part B) ____/____/____ Medicare # ________________________

BENEFIT ELECTIONS:

Medical Plan (Gp#_____)
Carrier: _______________
Plan:__________________

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

Dental Plan (Gp#________)
Carrier: _________________
Plan:___________________

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

Vision Plan (Gp#_________)
Carrier: __________________
Plan:___________________

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

EMPLOYER PAID BENEFITS (All Must Enroll)
Carrier:
√ Group Life √ Group STD √ Group LTD

CONTRIBUTORY OR VOLUNTARY BENEFITS
Carrier:
Please indicate your acceptance or refusal for any coverage under your employer's plan for which you are eligible:

Accept	Refuse		Amt/Coverage
☐	☐	**Emp Vol Life**	____________
☐	☐	**Emp Vol AD&D**	____________
☐	☐	**Spouse Vol Life**	____________
☐	☐	**Spouse Vol AD&D**	____________
☐	☐	**Dep Vol Life**	____________
☐	☐	**Dep Vol AD&D**	____________

Please note: Coverages for any Voluntary or Contributory program will not go into effect unless the policyholder meets the minimum Group participation requirements.

OTHER INSURANCE INFORMATION (Must Complete)

Did you or your dependents have prior coverage with another insurer? ☐ Yes ☐ No

Other Health Insurer Name/Policy # ________________________________ Insurer/Carrier Address ______________________________

Will you or your dependents described on this form continue with another insurer? ☐ Yes ☐ No

Who is covered? ☐ Self ☐ Spouse ☐ All Effective Date: ____________________ Term Date: _________________________

CERTIFICATION: I hereby elect, on behalf of myself and each listed dependent for the coverage(s) indicated. If accepted, coverage(s) will be provided according to the terms and conditions of the benefit plan(s) between my employer or (if Applicable) myself and I agree to be bound by the plans of which this form will become part. I also agree to pay current and future subscription charges for the coverage(s) provided if required by my employer. I have carefully read this Election 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.

EMPLOYEE SIGNATURE:____ **DATE**:_______________________
EMPLOYER SIGNATURE/VERIFICATION:____ **DATE:**_______________________

If you have any questions concerning the benefits and services that are provided, or excluded, by your employer, then please contact a member services representative at 410-494-0010 before signing this employee election form.