BOARD OF EDUCATION OF WICOMICO COUNTY
HEALTH INSURANCE ENROLLMENT FORM FOR CURRENT EMPLOYEES
Health Insurance Payments are Deducted Semi-Monthly from September through June for a Total of 20 Payroll Deductions for Coverage from
September 1, 2009 through August 31, 2010

The information listed below will assist employees in choosing benefits. *In addition to completing this enrollment form, you must also complete and attach a Carefirst Blue Cross and Blue Shield membership application to this form.*

CareFirst Blue Cross/Blue Shield Preferred Provider Organization (PPO/PPN)
with $5/25/40 Prescription Drug Program
Vision and Dental

Choose One Coverage Level:

	Coverage		Amount	
☐	Individual*	=	$ 29.00	per pay
☐	Employee & Spouse*	=	129.00	per pay
☐	Employee & One Child	=	92.00	per pay
☐	Family*	=	158.00	per pay
☐	Two-Earner Family*	=	58.00	per pay

CareFirst Blue Cross/Blue Shield Exclusive Provider Organization Plan (EPO)
with $5/25/40 Prescription Drug Program
Vision and Dental
No Reimbursement from CareFirst if Treated by Out of Network Doctor

Choose One Coverage Level:

	Coverage		Amount	
☐	Individual*	=	$ 27.00	per pay
☐	Employee & Spouse*	=	121.00	per pay
☐	Employee & One Child	=	86.00	per pay
☐	Family*	=	148.00	per pay
☐	Two Earner Family*	=	54.00	per pay

Is your spouse employed by the WCBOE? _____________YES* ________ NO
*If yes, print name of employee ____

I understand the above selection(s) may not be revoked or modified from 09/01/09 through 8/31/10, except in the case of a **qualifying life event as defined by the Internal Revenue Service** and as established in the enrollment guidelines of CareFirst BlueCross and BlueShield or required by state and federal law.

______________________________ ____
Date **Signature**

____
Name (Please Print)

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