

**BOARD OF EDUCATION OF WICOMICO COUNTY
HEALTH INSURANCE ENROLLMENT FORM FOR CURRENT EMPLOYEES**

September 1, 2007

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.*

MEDICAL BENEFITS

Option 1

**CareFirst Blue Cross/Blue Shield Preferred Provider Organization
with \$5/25/40 Prescription Drug Program**

Choose One Coverage Level:

- Individual = \$ 25.00 per pay
- Employee & Spouse* = 115.00 per pay
- Employee & One Child = 81.00 per pay
- Family* = 141.00 per pay

Is your spouse employed by the WCBOE? _____ YES* _____ NO

*If yes, print name of employee _____

If you have enrolled in the medical plan above, you may also elect to enroll in the Vision and Dental Program for the same level of coverage selected in Option 1

Option 2

**CareFirst BlueCross/Blue Shield
Vision and Dental Coverage**

Choose One Coverage Level:

- Individual = \$ 2.00 per pay
- Employee & Spouse = 7.00 per pay
- Employee & One Child = 5.00 per pay
- Family = 8.00 per pay

For your convenience, you may use this section to tally your total per pay deduction:

Option 1 _____
Option 2 _____
TOTAL PER PAY _____

I understand the above selection(s) may not be revoked or modified from 09/01/07 through 8/31/08, 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)