

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:

- 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:

- 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)**