CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

CareFirst BlueChoice, Inc. Enrollment Form

(Virginia Groups)

HOW TO COMPLETE THIS ENROLLMENT FORM:

1. Please type or print clearly with ball point pen.
2. Complete all appropriate items, sign and date.
3. **You MUST** include a Primary Care Physician name and code number for each dependent listed. The Physician Code # is located in the Provider Directory. **Failure to provide this information may delay in-network services.**
4. Please return your Form to your Employer.
5. **Employer must complete if Section VI is answered.** Number of employees in group ________________________.

I. APPLICANT

Employer/Group Administrator

Group Number ____________________________________

Effective Date Requested / /

Medical Option____________ Dental Option____________

Social Security Number

Date of Birth / /

Sex ☐ Male ☐ Female

Last Name | First Name | Initial

Date Employed / /

Occupation

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired

Residence Address *(Number and Street)* *(City and State)* *(Zip Code-9 digit, if known)*

Home Phone ( )

Work Phone ( )

Marital Status ☐ Single ☐ Married ☐ Other

Name of Primary Care Physician

Physician Code #

Current Patient ☐ Yes ☐ No

II. TYPE OF ENROLLMENT

CHECK ONE:

☐ New ☐ Coverage Change

III. TYPE OF COVERAGE

CHECK ONE:

☐ Self-Only Coverage
☐ Self and Spouse (Two-Party)
☐ Self and Child (Two-Party)
☐ Family
☐ Coverage Complementary to Medicare (Self-Only)

Coverage Selected: Check only those options that your employer has elected to offer.

☐ BlueChoice
☐ BlueChoice Opt-Out
☐ BlueChoice Opt-Out *Open Access*

☐ Dental HMO
☐ Dental HMO Opt-Out
☐ Preferred Dental
☐ Traditional Dental

IV. CHANGE TO EXISTING COVERAGE

Dependents affected by adds or deletes must be listed in Section V - Dependent Information

Identification Number, if different from Social Security Number

____

☐ *ADD* dependent(s) listed in Section V

☐ *ADD* spouse due to marriage on_______________________(Date)

☐ *ADD* child due to **adoption** on _______________________(Date) or appointed **legal guardian** by court decree dated_______________.
(Note: Documentation of adoption or court-appointed legal guardianship must be provided.)

☐ *REMOVE* dependent(s) listed in Section V due to____________________

_______________________(Reason)__________________(Date)

☐ *CHANGE* address to that shown in Section I above

☐ *CHANGE* my name from__________________________ to that shown in Section I

☐ *CHANGE* Primary Care Physician to that shown in Section I for applicant and Section V for dependent

CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

V. DEPENDENT INFORMATION

1	Spouse	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex ☐ Male ☐ Female
		Name of Primary Care Physician		Physician Code #	Current Patient ☐ Yes ☐ No
2	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex ☐ Male ☐ Female
		Name of Primary Care Physician		Physician Code #	Current Patient ☐ Yes ☐ No
3	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex ☐ Male ☐ Female
		Name of Primary Care Physician		Physician Code #	Current Patient ☐ Yes ☐ No
4	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex ☐ Male ☐ Female
		Name of Primary Care Physician		Physician Code #	Current Patient ☐ Yes ☐ No

COMPLETE ONLY IF DEPENDENT CHILD LISTED ABOVE IS AGE 19 OR OVER

Dependent Name - (Last, First, MI)	Full-Time Student?		Disabled?	
	☐ Yes ☐ No	**IF YES, ATTACH STUDENT CERTIFICA-TION Form**	☐ Yes ☐ No	**IF YES, ATTACH DISABILITY CERTIFICATION Form AND SUP-PORTING DOCU-MENTATION**
Dependent Name - (Last, First, MI)	Full-Time Student? ☐ Yes ☐ No		Disabled? ☐ Yes ☐ No	

VI. MEDICARE COVERAGE

FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, WILL CAUSE SIGNIFICANT PROCESSING DELAYS.

☐ Check this block if any person listed on this Form is eligible for or receiving benefits under Medicare. If you checked the block, please give:

Name_______________________ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No.____________________Eligible for: ☐ Part A Eff. Date____/____/____ ☐ Part B Eff. Date____/____/____

Name_______________________ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No.____________________Eligible for: ☐ Part A Eff. Date____/____/____ ☐ Part B Eff. Date____/____/____

EMPLOYEE STATUS: (CHECK ONLY ONE BOX) ☐ Actively Employed ☐ Retired

VII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

☐ Check this block if any person listed on this Form is now or has been enrolled within the last 31 days in health care or catastrophic coverage through a Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization, another insurance carrier or Medicaid. Is this coverage currently in effect? ☐ Yes ☐ No

If yes, will this coverage be continued? ☐ Yes ☐ No

If no, please provide cancellation date _______/_______/_______

1. Policy Holder's Name ________________________________ Date of Birth _______/_______/_______
2. Name and Location of Insurance Company ____
3. Policy Number________________________________ Effective Date_______/_______/_______
4. Policy Covers ☐ Policy Holder Only ☐ Two Persons ☐ Family
5. Is coverage through an employer or other group? ☐ Yes ☐ No
   Employer/Group Name ________________________________
6. Services Covered:

A. Hospital	☐ Yes	☐ No
B. Physician	☐ Yes	☐ No
C. Out-of-pocket Major Medical	☐ Yes	☐ No
D. Separate Drug Program	☐ Yes	☐ No
E. Dental	☐ Yes	☐ No
F. Eye or Vision Care	☐ Yes	☐ No
G. Mental Illness	☐ Yes	☐ No

VIII. PLEASE READ CAREFULLY - THIS SECTION MUST BE DATED AND SIGNED

IT IS UNDERSTOOD AND AGREED THAT:

(a) The statements and answers made herein are complete and correct to the best of my knowledge and belief, and are made to cause the issuance of, and to become a part of, the coverage applied for.

(b) The coverage will become effective according to your Group's eligibility guidelines following approval of this Form by CareFirst BlueChoice, Inc.

(c) Should any statements or answers contained in this Form be untrue (if such statements are fraudulent or material to the acceptance of this Form), then the coverage may be cancelled by CareFirst BlueChoice, Inc., and its obligation shall consist only of the return of any subscription charges actually paid, less the amount of any benefits paid under the coverage.

(d) The Subscriber shall repay to CareFirst BlueChoice, Inc. the amount of any payment made in error on behalf of the Subscriber or any covered family member as the result of a claim.

(e) A copy of this Form is available to the Subscriber (or a person authorized to act on his/her behalf) upon request.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under the coverage for which you are applying, please contact a membership services representative before signing this Form.

X ________________________________ **X** ________________________________

Date **Signature of Applicant**

CUT6191-4S (5/03)