

Individual CareFirst BlueChoice, Inc. Application



OFFICE USE ONLY:

(Maryland Residents)

ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

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

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Be sure to select a **Primary Care Physician (PCP) and PCP ID number** for all enrolled applicants.
3. Sign and return this application in the postage-paid return envelope.

Give careful attention to all questions in this application. *Accurate, complete* information is necessary before your application can be processed. **If incomplete, the application will be returned and delay your coverage.**



1. APPLICANT INFORMATION (The oldest applicant will be the Subscriber.)

Last Name		First Name		Initial	Social Security #
Residence Address (Number and Street, Apt. #)			(City and State)	Zip Code (9-digit, if known)	
Billing Address, if different from Residence Address: (Number and Street)			(City and State)	Zip Code (9-digit, if known)	
Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Partner		Height	Weight
Home Phone ()		Work Phone ()		E-mail Address	
Name of Primary Care Physician (PCP)				PCP ID Number	

2. COVERAGE SELECTION (Check one)

- Individual** - Provides coverage for one person
- Individual & Child(ren)** - Provides coverage for an individual and eligible dependent(s)
- Individual & Adult** - Provides coverage for two eligible adults
- Family** - Provides coverage for two eligible adults and eligible dependent(s)

COVERAGE LEVEL DESIRED:

CHECK ONE:	PCP/Specialist Copay	Inpatient Hospital	Prescription Drug
<input type="checkbox"/>	\$20/\$30	\$700 per admission	\$150 deductible, \$10/\$25/\$40, \$500 max
<input type="checkbox"/>	\$15/\$25	\$500 per admission	\$100 deductible, \$10/\$25/\$40, \$1000 max
<input type="checkbox"/>	\$10/\$20	\$250 per admission	\$50 deductible, \$10/\$25/\$40, \$1000 max

DENTAL BENEFITS:

Check here if you wish to include benefits for dental services (additional cost). Yes

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:			
Sub-Agent/Sub-Agency:			
Writing Agent:			

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3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child(ren), Individual & Adult or Family Coverage

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	HT (in.)	WT (lbs.)	Medical Center or PCP Name (Include PCP ID #)
Spouse/Partner						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 5						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #

4. OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Is anyone listed on this application eligible for Medicare? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please provide the following: | | |
| Name of family member(s) _____ Medicare No. _____ Effective Date _____ | | |
| 2. Is anyone listed on this application covered by other health insurance, including other Blue Cross and Blue Shield coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please provide the following: | | |
| Name of family member(s) _____ Insurance Company _____ | | |
| Policy Number and Type _____ Effective Date _____ | | |
| If you are accepted, will your new CareFirst BlueChoice coverage replace your existing policy? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has anyone listed on this application been without health insurance for the past 12 months or longer? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list name(s): _____ | | |

5. HEALTH EVALUATION

PLEASE COMPLETE SECTIONS A, B, AND C. CHECK EACH ITEM “YES” OR “NO”. Answering yes will not necessarily result in the rejection of your application.

	YES	NO
Have you or any family member named in the accompanying application had a physical examination within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 5A — To the best of your knowledge or belief, has any person named in this application had within the last five years, or does such person now have, any of the following:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Cancer, tumor or other growth (malignant or benign) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Kidney stones, kidney or bladder condition, urinary frequency or burning | <input type="checkbox"/> | <input type="checkbox"/> |

5. HEALTH EVALUATION (Continued)

	YES	NO
4. Goiter, thyroid condition, diabetes	<input type="checkbox"/>	<input type="checkbox"/>
5. Seizure disorder, central nervous system disorder, multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
6. Substance abuse (drug or alcohol dependency, abuse or addiction)	<input type="checkbox"/>	<input type="checkbox"/>
7. Use of illicit drugs	<input type="checkbox"/>	<input type="checkbox"/>
8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	<input type="checkbox"/>	<input type="checkbox"/>
9. Cataract or other eye condition	<input type="checkbox"/>	<input type="checkbox"/>
10. Tuberculosis, lung condition, asthma, bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	<input type="checkbox"/>	<input type="checkbox"/>
12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)	<input type="checkbox"/>	<input type="checkbox"/>
13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition	<input type="checkbox"/>	<input type="checkbox"/>
14. (Female) Is currently pregnant; expected date of delivery: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
15. (Male) Prostate condition, reproductive system disorders, infertility	<input type="checkbox"/>	<input type="checkbox"/>
16. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	<input type="checkbox"/>	<input type="checkbox"/>
17. Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
18. Anemia, blood disorders	<input type="checkbox"/>	<input type="checkbox"/>
19. Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or prescription medication for a medical condition NOT listed above in items 1-18?	<input type="checkbox"/>	<input type="checkbox"/>
20. Had any known departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought?	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” – Or your application will be returned.

SECTION 5B — If you have checked “YES” to any part of SECTION 5A, for each box checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Patient's First Name	Question Number	Diagnosis or Condition	Duration Dates	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician's/hospital's name.	Recovery (Check only one box.)
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL

NOTE: FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN VOIDING OF MEMBERSHIP AND DENIAL OF BENEFITS.

5. HEALTH EVALUATION (Continued)

SECTION 5C — If any person included in this application is presently using medication or prescription drugs, please provide the following information.

Name of Family Member	Illness or Condition	Date of Last Treatment	Operation (Yes or No)	Attending Physician Name and Address

6. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request, from CareFirst BlueChoice, Inc. (CareFirst BlueChoice).

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst BlueChoice policy. I understand that a medically underwritten policy is only issued under the conditions that the health of all persons named on the application remains as stated above. I also understand that failure to enter accurate, complete and updated medical information may result in the denial of all benefits, cancellation or voiding of my policy.

I will update CareFirst BlueChoice if there have been any changes in health concerning any person listed in this application that occurs prior to acceptance of this application by CareFirst BlueChoice.

IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY OR EXCLUDED UNDER THIS AGREEMENT, PLEASE CONTACT A MEMBERSHIP SERVICES REPRESENTATIVE BEFORE SIGNING THIS APPLICATION.

WARNING: It is a fraudulent insurance act for a person knowingly or willfully to make a false or fraudulent statement or representation in or with reference to this application of insurance.

Signature of Applicant 1:* X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____

Re-sign and re-date below **only** if box is checked.

Signature of Applicant 1: X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____

* Rates are based on the age of the Subscriber (oldest applicant).

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

Parent or Legal Guardian's Signature: X _____ Date: _____