



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

CareFirst BlueChoice, Inc. Enrollment Form

(Maryland Groups)

THIS IS NOT AN APPLICATION FOR INSURANCE

HOW TO COMPLETE THIS ENROLLMENT FORM:

- Please type or print clearly with ball point pen.
- Complete all appropriate items, sign and date.
- 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.**
- Please return your Form to your Employer.
- Employer must complete if Section VI is answered.** Number of employees in group _____.

I. APPLICANT

Employer/Group Administrator		Group Number _____	
		Medical Option _____ Dental Option _____	
Effective Date Requested / /		Vision Option _____	
Social Security Number		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name		First Name	Initial
Date Employed / /	Occupation	Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired	
Residence Address (Number and Street)		(City and State)	(Zip Code-9 digit, if known)
Home Phone ()	Work Phone ()	Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Partner <input type="checkbox"/> Other <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced	
Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

II. TYPE OF ENROLLMENT

CHECK ONE:

- New Coverage Change

III. TYPE OF COVERAGE

Please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section to avoid delays in processing this Enrollment Form.

CHECK ONE:

- Individual
 Individual and Adult (Two-Party coverage)
 Individual and Child
 Individual and Children
 Family
 Coverage Complementary to Medicare (Individual Only)

CHECK ONE:

- BlueChoice
 BlueChoice *Open Access*
 BlueChoice *Opt-Out Open Access*
- Dental HMO
 Dental HMO Opt-Out
 Preferred Dental
 Traditional Dental
 BlueVision *Plus*

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* partner 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. CareFirst BlueChoice will pay the cost of the documentation required to provide proof of adoption or court-appointed legal guardianship.)

- 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

V. DEPENDENT INFORMATION

1	Spouse/ Partner	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
2	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
3	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
4	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Dependent Name - (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH STUDENT CERTIFICA- TION FORM	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH DISABILITY CERTIFICATION Form AND SUP- PORTING DOCU- MENTATION
Dependent Name - (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Physician | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Out-of-pocket Major Medical | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Separate Drug Program | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Dental | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Eye or Vision Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Mental Illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this Form is accepted, coverage will be provided according to the terms and conditions of the contract between CareFirst BlueChoice, Inc. and my employer. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I have carefully read this Form and agree to its terms. The recorded answers on this Form are, to the best of my knowledge and belief, full, complete and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your Form and/or claims payment.

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 _____
Signature of Applicant Date