

Individual BluePreferred Health Savings Account (HSA) Plan Application

(Maryland Residents)



Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065

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

INSTRUCTIONS

- Please fill out all applicable spaces on this application. Print or type all information.
- Sign and return this application in the postage-paid return envelope if provided, or mail to CareFirst BlueCross BlueShield, Individual Market Division/02-225, 10455 Mill Run Circle, Owings Mills, MD 21117-9685.

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

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, Apt. #)				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				

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:	Deductible (In-Network)	Coverage Level (In-Network)	Out-of-Pocket Max (In-Network)
<input type="checkbox"/>	\$1,200 (Individual) / \$2,400 (Family aggregate)	80%	\$2,800 (Individual) / \$5,600 (Family aggregate)
<input type="checkbox"/>	\$2,700 (Individual) / \$5,400 (Family aggregate)	100%	\$3,200 (Individual) / \$6,400 (Family aggregate)

IMPORTANT DEDUCTIBLE INFORMATION

Individual Coverage: A Member who has Individual Coverage must satisfy the Individual Deductible.

Individual & Child(ren), Individual & Adult, and Family Coverage: Members who have Individual & Child(ren), Individual & Adult, and Family Coverage must combine the eligible expenses of all covered Members to satisfy the family aggregate Deductible. A Member is not entitled to payment of benefits until the family aggregate Deductible is satisfied.

2. COVERAGE SELECTION (Continued)

IMPORTANT OUT-OF-POCKET LIMIT INFORMATION

Individual Coverage: A Member who has Individual Coverage must satisfy the Individual Out-of-Pocket Limit.

Individual & Child(ren), Individual & Adult, and Family Coverage: Members who have Individual & Child(ren), Individual & Adult, and Family Coverage: must combine the eligible expenses of all covered Members to satisfy the family aggregate Out-of-Pocket Limit. When the family aggregate In-Network Out-of-Pocket Limit is reached by one or more members of the family, no further copayments, coinsurance, or deductibles will be required in that Benefit Period for In-Network services. Members who meet the Maximum Combined Out-of-Pocket Limit automatically satisfy the In-Network and Out-of-Network Out of Pocket Limit for that Benefit Period.

MATERNITY BENEFITS: Check this box if you wish to include benefits for maternity services (additional cost). Yes

VISION BENEFITS: Check this box if you wish to include benefits for vision services (additional cost). Yes

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.)
Spouse/Partner						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 5						<input type="checkbox"/> M <input type="checkbox"/> F		

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? YES NO
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? YES NO

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 BlueCross BlueShield coverage replace your existing policy? YES NO

3. Has anyone listed on this application been without health insurance for the past 12 months or longer? YES NO
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 this application had a physical examination within the past five years? YES NO

5. HEALTH EVALUATION (Continued)

YES NO

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:

1. Cancer, tumor or other growth (malignant or benign) YES NO
2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test) YES NO
3. Kidney stones, kidney or bladder condition, urinary frequency or burning YES NO
4. Goiter, thyroid condition, diabetes YES NO
5. Seizure disorder, central nervous system disorder, multiple sclerosis YES NO
6. Substance abuse (drug or alcohol dependency, abuse or addiction) YES NO
7. Use of illicit drugs YES NO
8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition YES NO
9. Cataract or other eye condition YES NO
10. Tuberculosis, lung condition, asthma, bronchitis YES NO
11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition YES NO
12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke) YES NO
13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition YES NO
14. (Female) Is currently pregnant; expected date of delivery: ____/____/____ YES NO
15. (Male) Prostate condition, reproductive system disorders, infertility YES NO
16. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder YES NO
17. Sexually transmitted diseases YES NO
18. Anemia, blood disorders YES NO
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? YES NO
20. Had any departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought? YES NO

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” – Or your application will be returned. FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN VOIDING OF MEMBERSHIP AND DENIAL OF BENEFITS.

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	Medication	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 Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst).

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 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 if there have been any changes in health concerning any person listed in this application that occur prior to acceptance of this application by CareFirst.

By signing this Application, I hereby authorize CareFirst BlueCross BlueShield to disseminate and share non-health questionnaire information contained on this Application with the Health Savings Account (HSA) preferred bank(s) affiliated with CareFirst BlueCross BlueShield. I understand that dissemination of information to any such bank is at my direction and with my full understanding. Further that dissemination of information on this Application, excluding health questionnaire information, is necessary in order to effectuate the establishment of a Health Savings Account in my name with the HSA bank. The authorization shall continue until my enrollment with CareFirst BlueCross BlueShield terminates or at any time that I provide a written instruction to CareFirst BlueCross BlueShield revoking this authorization or if this authorization terminates by operation of law.

If you do not want information on this Application shared with the HSA preferred bank(s) please check here.

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 for insurance.

Signature of Applicant 1:* **X** _____ Date: _____

Signature of Applicant 2: **X** _____ Date: _____

*Rates are based on the age of the Subscriber.

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: _____

For Office Use Only:

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

Signature of Applicant 1: **X** _____ Date: _____

Signature of Applicant 2: **X** _____ Date: _____

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