

Individual CareFirst BlueChoice Conversion/HIPAA Application



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

OFFICE USE ONLY:

(Virginia Residents)

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

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.***

TYPE OF ENROLLMENT (CHECK ONE)

- Group Conversion HIPAA

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			
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:		
CHECK:	PCP/Specialist Copay	Inpatient Hospital
<input type="checkbox"/>	\$20/\$30	\$700 per admission

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

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	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 Group Conversion/HIPAA 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. HIPAA ELIGIBILITY INFORMATION

	YES	NO
1. Are any applicant(s) eligible (whether enrolled or not) for coverage under any group health benefits plan or employer sponsored health benefit plan?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please state the name(s) of the applicant(s) _____		
2. Are any applicant(s) eligible or entitled (whether enrolled or not) for Medicare, Part A or Part B?	<input type="checkbox"/>	<input type="checkbox"/>
If entitled, please state the name(s) of the applicant(s) _____		
and the applicant's Medicare Claim Number _____		
3. Are any applicant(s) eligible (whether enrolled or not) for Medicaid, or any similar state plan under Title XIX of the Social Security Act?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please state the name of the applicant(s) _____		
4. Are any applicant(s) currently covered under any other health benefit plan?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please state the name of the applicant(s) _____		
Provide coverage information in Section 5 (Other Insurance Information), above.		

5. HIPAA ELIGIBILITY INFORMATION

5. Was the applicant's prior health benefits plan terminated because of nonpayment of premium or subscription charges by the applicant?

If yes, please state the name of the applicant(s) _____

6. Was the applicant's prior health benefits plan terminated for reasons of fraudulent act or intentional misrepresentation by the applicant?

If yes, please state the name of the applicant(s) _____

Federal law requires that a group health plan sponsored by an employer who regularly employs 20 or more employees offer employees and their families the opportunity for a temporary extension of health coverage called Continuation Coverage (or COBRA coverage). This Continuation Coverage is offered for a specific number of months depending on the applicant's situation. The employer or Plan Administrator will be able to tell an applicant(s) how many months of Continuation Coverage is available.

7. If the applicant(s) were offered this Continuation Coverage, did the applicant(s) refuse this coverage or elect to terminate this coverage before the end of the allowed Continuation Coverage period?

If yes, please state the name of the applicant(s) _____

INSTRUCTIONS:

Applicants REQUIRED to Complete the Health Status Section of the Application:

- Any applicant who has not been covered under any health benefits plan for the past 63 days.
- Any applicant who answered any of the above questions in Section 5 (HIPAA Eligibility Information) with "YES".
- Any applicant who wants to be considered for the Underwritten coverage only or for both the Underwritten coverage (first choice) and the HIPAA coverage (second choice).

Applicants who are NOT Required to Complete the Health Status Section of the Application:

- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 18 months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under individual health insurance coverage, a group health plan, governmental plan, or church plan, or any health benefit plan offered in connection with these plans; and 3) the applicant answered all of the above questions in Section 5 (HIPAA Eligibility Information) with "NO".
- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 12 months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under an individual health insurance policy which was nonrenewed by the health insurance issuer because the health insurance issuer is no longer offering any type of health insurance coverage in the individual market; and 3) the applicant answered all of the above questions in Section 5 (HIPAA Eligibility Information) with "NO".

NOTE: An applicant's prior insurer(s) or health plan(s) are required by federal law to provide a Certificate of Coverage that indicates how many months the applicant has been continuously covered under "creditable coverage", as defined under Federal and State law. Please attach all Certificates of Coverage to this application. Retain a copy for your records.

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 occurs prior to acceptance of this application by CareFirst.

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: _____

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.

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: _____