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

840 First Street, NE
Washington, DC 20065
202-479-8000
Independent licensees of the Blue Cross and Blue Shield Association
Insurer(s) identified above is (are) responsible for the obligations in this Selection Form
(Selection of one or both of the above is required)

Selection Form
For Continuation of Group Coverage
For Those Groups Not Eligible for COBRA, or When COBRA is Not Selected

This selection form is for continued group coverage in accordance with Virginia statute and Bureau of Insurance regulations. These regulations enable a member of the group or a family member to continue group coverage (including dental, drug or vision coverage) for up to ninety (90) days after the member ceases to be an eligible employee of the group, as long as the member meets certain requirements. The member must pay the full cost of coverage during this period. The member must not be eligible for Medicare or Medicaid benefits. If a member wishes to continue coverage he or she is not eligible for non-group conversion coverage. Neither CareFirst, CareFirst BlueChoice, nor their representatives act as an administrator for continuation of group coverage. This form is not an application for insurance. This form is for data collection purposes only. The above description of continuation of coverage and continuation of coverage procedures is general in nature**.**

Name of Participant(s):____

____

____

Identification Number: ____

Social Security Number: ____

Participant's Address:
____

Home Telephone Number: (   )___________ Work Telephone Number: (   )_____________

Group Name: ___________________________ Group Number: ___________

Participant's Statement

I certify that, to the best of my knowledge and belief, my group coverage has been effective for at least three months.

I understand and agree that in the event I cease to be eligible for continuation of group coverage for any reason, I must notify my former employer immediately.

Signature of Participant and Date ____

To Be Completed By the Plan Administrator

1. Date of termination of participant's employment: ______________________________

2. $ ________ is the amount I will collect and remit each month for the continuation of group coverage for this participant.

Signature of Plan Administrator and Date

____

Please Return This Form To:

CareFirst BlueCross BlueShield / CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
Attention: Account Implementation Department
Mailstop 31

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