

CareFirst BlueChoice, Inc.

840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

**GROUP ENROLLMENT AGREEMENT APPLICATION
AND
ENROLLMENT INFORMATION FORM
Renewing Self-Employed Individuals**

<input type="checkbox"/> APPLICATION FOR GROUP ENROLLMENT AGREEMENT (Existing Self-Employed Individual) <ul style="list-style-type: none"> • Please provide your Group Number: _____. • Fill in your name in Part I of this application and complete only those areas in which information is changing. • Sign and date Part III. <input type="checkbox"/> CHANGE IN ENROLLMENT INFORMATION (Existing Self-Employed Individual) <ul style="list-style-type: none"> • Please complete Part II, only. • Sign and date Part III.
--

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact your Sales Representative or broker before signing this application.

PART I: APPLICATION FOR RENEWING SELF-EMPLOYED INDIVIDUAL GROUP ENROLLMENT AGREEMENT

Self-Employed Individual: _____

Name of Firm/Business: _____
(If different than individual)

Physical Location: _____

Street

City

State

Zip

Mailing Address: _____
(if other than above)

Street

City

State

Zip

Home Phone Number: (____) _____ Work Phone Number: (____) _____

Nature of Business: _____ Federal Tax Identification Number: _____

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements To maintain your eligibility as a Self-Employed Individual, you must meet all requirements for a Self-Employed Individual as provided under the Maryland Small Employer Insurance Business Reform Law. You must meet the following requirements:

- You must work and reside in the State of Maryland and be a Self-Employed Individual organized as a sole proprietorship or, in any other legally recognized manner that a Self-Employed Individual may organize such that a substantial portion of your income is derived from a trade or business through which you have attempted to earn taxable income and for which you have filed the appropriate Internal Revenue form or forms and schedule for the previous taxable year, a copy of which shall be filed with CareFirst BlueChoice; or
- You must be a Self-Employed Individual enrolled on September 30, 2005 in a health benefit plan offered by CareFirst BlueChoice under Title 15, Subtitle 12 of the Insurance Article and may at the option of the Self-Employed Individual remain covered under any policy issued by CareFirst BlueChoice to Small Employers and selected by the Self-Employed Individual at renewal.
- A Self-Employed Individual who met the definition of “Self-Employed” will be permitted to renew their coverage for as long as they continue to meet the definition in effect on the date they originally applied for coverage.

Your Sales Representative, or broker can help you obtain additional detailed information about the requirements of the Maryland Small Employer Insurance Business Reform Law.

Evidence of Eligibility If you are changing coverage as an existing Self-Employed Individual Group, you must include the following documentation with your application to verify that you qualify as a Self-Employed Individual Group:

- If you filed appropriate Internal Revenue Form or Forms and Schedule for the previous taxable year, include copies of these documents with your application.
- If you filed a different Internal Revenue form, forms or schedule for your trade or business in the previous taxable year, include copies of the applicable form, forms or schedule with your application.

If you have any questions about the correct documentation to submit with your application, your Sales Representative can help you select the most appropriate documentation. Once we receive your application, we will notify you if additional documents or information is required.

Eligibility Certification CareFirst BlueChoice reserves the right to inspect your records in order to verify your eligibility and the eligibility of your Dependents.

Annual Renewal Period You may apply for a change in benefits or add eligible Dependents not previously enrolled only during your annual renewal period. During the annual renewal period existing Self-Employed Individuals enrolled in CareFirst BlueChoice may change their type of benefits to any other small employer product offered by CareFirst BlueChoice. If an existing Self-Employed Individual does not apply for a change in their benefits and or coverage during the annual renewal period, the Self-Employed Individual must wait until the next annual renewal period. It is important you know that a change in your benefits to another small employer product or a change in the level of your coverage may result in a change to your premium.

PART II: ENROLLMENT INFORMATION FORM

I. SELF-EMPLOYED INDIVIDUAL					
Last Name	First Name	Initial	Social Security Number		
Residence Address (Number and Street)		(City and State)	(Zip Code-9 digit if known)		
Home Phone Number: (____) _____ Work Phone Number: (____) _____					
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					
Date of Birth	Sex	Select Your Primary Care Physician	Physician Code#	Current Patient	
Month Day Year	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No	
II. TYPE OF ENROLLMENT					
<input type="checkbox"/> Change Type of Coverage <input type="checkbox"/> Change Type of Benefits					
III. TYPE OF COVERAGE					
<input type="checkbox"/> Individual <input type="checkbox"/> Individual and Adult <input type="checkbox"/> Individual and Child(ren) <input type="checkbox"/> Family					
IV. CHANGE TO EXISTING COVERAGE					
Dependents affected by changes must be listed in Dependent Information in Section V. below.					
Identification number, if different than Social Security Number: _____					
<input type="checkbox"/> Add Dependent(s) listed in Section V. below.					
<input type="checkbox"/> Add spouse due to marriage on _____ (date); <input type="checkbox"/> Add partner on _____ (date).					
<input type="checkbox"/> Add child due to adoption on _____ (date) or appointed legal guardian by court decree dated _____ (date).					
<input type="checkbox"/> Add grandchild due to court ordered custody on _____ (date) or date a grandchild is placed in the court order custody dated _____ (date).					
Note: Documentation of adoption, court-appointed legal guardianship or court ordered custody must be provided.					
<input type="checkbox"/> Remove Dependent(s) due to _____ (reason) on _____ (date).					
<input type="checkbox"/> Change residence address to address shown in Section I. above.					
<input type="checkbox"/> Change name from _____ to name shown in Section I. above.					
<input type="checkbox"/> Change Primary Care Physician to that shown in Section I. for applicant and Section V. for Dependent.					

V. DEPENDENT INFORMATION: Complete only if you select other than Individual Coverage

Adult <input type="checkbox"/> Add <input type="checkbox"/> Remove	Name (Last, First, MI)	Social Security No.	Date Of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
	Name of Primary Care Physician		Physician Code#		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
Child <input type="checkbox"/> Add <input type="checkbox"/> Remove	Name (Last, First, MI)	Social Security No.	Date Of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
	Name of Primary Care Physician		Physician Code#		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
Child <input type="checkbox"/> Add <input type="checkbox"/> Remove	Name (Last, First, MI)	Social Security No.	Date Of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
	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's Name (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH STUDENT CERTIFICATION FORM	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH DISABILITY CERTIFICATION FORM AND SUPPORTING DOCUMENTATION
Dependent's 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

Check this block if any person listed on this application is eligible for or receiving benefits under Medicare. If you checked the block, please give:

Name _____ Medicare Claim No. _____

Eligible for: Part A Effective Date: _____

Part B Effective Date: _____

Reason for entitlement: Age 65 or older End stage renal disease Disabled

Employment Status (check one): Active Retired

Beginning date of renal treatment, if applicable: _____

VII. PRIOR COVERAGE/OTHER INSURANCE INFORMATION

If you have other insurance, failure to complete this section will cause significant delays in processing any claims submitted.

Check this block if any person listed on this application is now or has been enrolled within the last 31 days in health care or catastrophic coverage through CareFirst BlueChoice, another Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization, or another insurance carrier. 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: _____ Sex: M F Date of Birth: _____

2. Name and Address of Insurance Company: _____

3. Policy Number: _____ Policy Covers: Policy Holder Only Two Persons Family

4. Effective Date of Policy: _____

5. Service(s) Covered:

- A. Hospital Services Yes No
- B. Physician Services Yes No
- C. Major Medical (out-of-pocket expenses) Yes No
- D. Separate Drug Program Yes No
- E. Dental Yes No
- F. Eye/Vision Care Services Yes No
- G. Mental Illness Services Yes No
- H. HMO Yes No

6. Is coverage through an employer or other group? Yes No

If yes, name of employer or other group: _____

7. Is this coverage under COBRA? Yes No

If yes, reason for cancellation: _____

8. To be completed if the natural parents live apart and provide medical coverage for their children. Please indicate relationship to children (natural mother, natural father, step-parent):

Parent with court assigned responsibility for child(ren)'s medical expenses

Parent's Name/Relationship

Child's Name/Date of Birth

Parent with custody of child(ren)

Parent's Name/Relationship

Child's Name/Date of Birth

NOTE: YOU MUST SIGN AND DATE PART III OF THIS APPLICATION

PART III: OTHER TERMS

Agreements and Understandings By signing below, you agree to the following:

1. You acknowledge that the statements you have made and information you have provided in this application are provided to cause the continuation of previously issued health care coverage, and to become a part of, the coverage applied for and you represent that such statements and information are complete and correct to the best of your knowledge and belief.
2. A statement made by any person covered under this Agreement relating to insurability may not be used in contesting the validity of the coverage with respect to which the statement was made after the coverage has been in force before the contest for a period of 2 years during the person's lifetime.
3. You agree to repay to CareFirst BlueChoice the amount of any payments made in error to you.

As an existing Self-Employed Group, CareFirst BlueChoice will either issue a new Agreement and Evidence of Coverage (if there are substantial changes) or amend your current Agreement and Evidence of Coverage. CareFirst BlueChoice can amend your Agreement through acceptance and approval of this application or by issuing a new Rider, Amendment, or Endorsement to your Agreement.

Signature _____ *Date* _____
(Self-Employed Individual)

Amount Enclosed: \$ _____

Broker/Plan Representative Information

(Name of Broker or Sales Representative) Broker or Rep. Code ID # _____

CareFirst Blue Choice, Inc. Approval:

By _____ *Date* _____
Director, Account Implementation

Effective Date of Group Coverage _____