

# ATTENTION

Please note that the Conditions of Enrollment on page 3 of the application for enrolling in the BlueChoice Open Enrollment plan have changed.

You **must** include proof of DC residency with your application. Acceptable forms of documentation include:

- A copy of the front of your current DC driver's license or DC ID card
- A copy of your utility bill
- A copy of your rental agreement
- A copy of your DC voter registration card
- A copy of your DC Resident Income Tax return
- A copy of your property taxes

**Without this documentation, your application cannot be processed.**

If you have any questions about the plan or need assistance, please call our Product Specialists at 800-544-8703.

Thank you.

# Individual CareFirst BlueChoice Open Enrollment Application



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

OFFICE USE ONLY:

(District of Columbia Residents)

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

## INSTRUCTIONS

- Please fill out all applicable spaces on this application. Print or type all information.
- Be sure to select a **Primary Care Physician (PCP) and PCP ID number** for all enrolled applicants.
- Sign and return this application in the postage-paid return envelope if provided, or mail to:  
**CareFirst BlueCross BlueShield  
Individual Market Division/RR291  
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 (The oldest applicant will be the Subscriber)

Last Name		First Name		Initial	Social Security #	
Residence Address: (Number and Street, Apt. #)				Ward	City and State	Zip Code (9-digit, if known)
Billing Address, if different from Residence Address: (Number and Street, Apt. #)				Ward	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 <input type="checkbox"/> Domestic Partnership		
Home Phone ( ) ( )		Work/Cell 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)

## 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/ Domestic 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#

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

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#### 4. COVERAGE LEVEL

PCP/Specialist Copay	Inpatient Hospital	Prescription Drug
\$10/\$20	\$500 per admission	\$100 deductible, \$10/\$60/\$80, \$1,500 max

#### 5. 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 BlueChoice 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): \_\_\_\_\_

#### 6. ADDITIONAL INFORMATION (OPTIONAL)

**INDICATE TOTAL ANNUAL HOUSEHOLD INCOME INCLUDING WAGES, SOCIAL SECURITY, INVESTMENT INCOME, ALIMONY ETC.**

(Check one)

- \$0 – \$12,490       \$25,001 – \$35,000       \$45,001 – \$55,000       \$65,001 – \$75,000  
 \$12,491 – \$25,000       \$35,001 – \$45,000       \$55,001 – \$65,000       \$75,001 or more

CareFirst BlueChoice, Inc. invites you to voluntarily identify your race or ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

- American Indian/Alaska Native       Asian       Black/African American  
 Hispanic/Latino       Native Hawaiian/Other Pacific Islander  
 Not Specified       White

**7. 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 CareFirst BlueChoice, Inc. (CareFirst BlueChoice). The information provided on this application is subject to verification. To do so, you acknowledge that CareFirst could use information from our own systems, or information available from a commercial third party data provider. Further, you acknowledge that this information will be used, in part, to determine your eligibility.

At any time during membership in the HMO Open Enrollment plan, CareFirst BlueChoice has the right to require proof of residency in the District of Columbia. Acceptable forms of documentation include:

- A copy of the front of your current DC driver’s license or DC ID card
- A copy of your utility bill
- A copy of your rental agreement
- A copy of your voter registration card
- A copy of your DC Resident Income Tax Return
- A copy of your property taxes

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations made to induce the issuance of, and form part of the consideration for a CareFirst BlueChoice policy. Failure to complete any section may delay the processing of your application and/or claims payment.

**IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY, OR EXCLUDED UNDER, THIS AGREEMENT, PLEASE CONTACT A PRODUCT SPECIALIST AT (800) 544-8703, BEFORE SIGNING THIS APPLICATION.**

**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.**

Signature of Applicant 1:\* X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Applicant 2: X \_\_\_\_\_ Date: \_\_\_\_\_  
(Spouse/Domestic Partner)

\* Rates are based on the age of the Subscriber (oldest applicant).

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.

Signature of Parent or Legal Guardian: X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Eligible Dependent: X \_\_\_\_\_ Date: \_\_\_\_\_

Must be 18 years of age or older

**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: \_\_\_\_\_  
(Spouse/Domestic Partner)