

Individual Select Dental Application

OFFICE USE ONLY: (District of Columbia and Virginia Residents)

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



840 First Street, NE, Washington, DC 20065

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
 2. 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.***

SELECT YOUR PLAN (Check one)

- Individual Select DHMO CareFirst BlueChoice, Inc. Individual Select Preferred Group Hospitalization and Medical Services, Inc.

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	Plan Type <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual
Home Phone ()	Work Phone ()	E-mail Address	

2. COVERAGE SELECTION FOR DENTAL HMO: (Check one)

- Individual** - Provides coverage for one person
 Individual & Child - Provides coverage for an individual and eligible dependent (if you have more than one child, you must select Family coverage)
 Individual & Adult - Provides coverage for two eligible adults
 Family - Provides coverage for up to two eligible adults and eligible dependent(s)

COVERAGE SELECTION FOR PREFERRED: (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

(Dental HMO Plan must have a dental code. Each person can select their own dentist.)

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	Dental Office Code (DHMO Plan only)
Member						<input type="checkbox"/> M <input type="checkbox"/> F	
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	

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. © Registered trademark of the Blue Cross and Blue Shield Association. © Registered trademark of CareFirst of Maryland, Inc.

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

Is anyone listed on this application covered by other dental 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 _____

5. 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. 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.

Premium payment options are available on an annual and a semi-annual basis. Those members who elect the semi-annual payment option will be subject to a five dollar (\$5) surcharge per payment, which equates to ten dollars annually.

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.

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 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, CareFirst BlueChoice, Inc., or CareFirst BlueCross BlueShield may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

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 Signature: X _____ **Date:** _____

If you have selected Individual Select DENTAL HMO	If you have selected Individual Select PREFERRED
<p>Please make checks payable to CAREFIRST BLUECHOICE, INC. and mail to: P.O. Box 79810 Baltimore, MD 21279-0810</p>	<p>Please make checks payable to CAREFIRST BLUECROSS BLUESHIELD and mail to: P.O. Box 79810 Baltimore, MD 21279-0810</p>

FOR INTERNAL USE ONLY:

Agency Name		
Agency Address (Number and Street, Apt.#)		Zip Code (9-digit, if known)
Telephone Number ()	Fax Number ()	E-mail Address
Annual Premium		