



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

# CareFirst BlueChoice, Inc. Enrollment Form (Maryland Groups)

**HOW TO COMPLETE THIS ENROLLMENT FORM:**

1. Please type or print clearly with ball point pen.
2. Complete all appropriate items, sign and date.
3. **You MUST** include a Primary Care Physician name and code number for each dependent listed. The Physician Code # is located in the Provider Directory. **Failure to provide this information may delay in-network services.**
4. Please return your Form to your Employer.
5. **Employer must complete if Section VI is answered.** Number of employees in group \_\_\_\_\_.

I. APPLICANT			
Employer/Group Administrator		Group Number _____	
Effective Date Requested     /     /		Medical Option _____ Dental Option _____	
Social Security Number		Date of Birth     /     /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name		First Name	Initial
Date Employed /     /	Occupation	Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired	
Residence Address (Number and Street)		(City and State)     (Zip Code-9 digit, if known)	
Home Phone (   )	Work Phone (   )	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
II. TYPE OF ENROLLMENT		IV. CHANGE TO EXISTING COVERAGE	
<b>CHECK ONE:</b> <input type="checkbox"/> New <input type="checkbox"/> Coverage Change		<b>Dependents affected by adds or deletes must be listed in Section V - Dependent Information</b> Identification Number, if different from Social Security Number _____	
III. TYPE OF COVERAGE		<input type="checkbox"/> ADD dependent(s) listed in Section V <input type="checkbox"/> ADD spouse due to marriage on _____ (Date) <input type="checkbox"/> ADD child due to <b>adoption</b> on _____ (Date) or appointed <b>legal guardian</b> by court decree dated _____. <b>(Note: Documentation of adoption or court-appointed legal guardianship must be provided. CareFirst BlueChoice will pay the cost of the documentation required to provide proof of adoption or court-appointed legal guardianship.)</b> <input type="checkbox"/> REMOVE dependent(s) listed in Section V due to _____ _____ (Reason) _____ (Date)	
<b>CHECK ONE:</b> <input type="checkbox"/> Self-Only Coverage <input type="checkbox"/> Self and Spouse (Two-Party) <input type="checkbox"/> Self and Child (Two-Party) <input type="checkbox"/> Family <input type="checkbox"/> Coverage Complementary to Medicare (Self-Only)		<input type="checkbox"/> CHANGE address to that shown in Section I above <input type="checkbox"/> CHANGE my name from _____ to that shown in Section I <input type="checkbox"/> CHANGE Primary Care Physician to that shown in Section I for applicant and Section V for dependent	
<b>Coverage Selected:</b> Check only those options that your employer has elected to offer. <input type="checkbox"/> BlueChoice <input type="checkbox"/> BlueChoice Opt-Out <input type="checkbox"/> BlueChoice Opt-Out <i>Open Access</i>  <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental HMO Opt-Out <input type="checkbox"/> Preferred Dental <input type="checkbox"/> Traditional Dental			

## V. DEPENDENT INFORMATION

<b>1 Spouse</b>	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2 Child</b>	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3 Child</b>	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4 Child</b>	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	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 Name - (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>IF YES, ATTACH STUDENT CERTIFICA- TION Form</b>	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>IF YES, ATTACH DISABILITY CERTIFICATION Form AND SUP- PORTING DOCU- MENTATION</b>
Dependent 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

### FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, WILL CAUSE SIGNIFICANT PROCESSING DELAYS.

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

Name \_\_\_\_\_ Reason for entitlement:  Age 65 or older  Kidney disease  Disabled

Medicare Claim No. \_\_\_\_\_ Eligible for:  Part A Eff. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Part B Eff. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Reason for entitlement:  Age 65 or older  Kidney disease  Disabled

Medicare Claim No. \_\_\_\_\_ Eligible for:  Part A Eff. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Part B Eff. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYEE STATUS: (CHECK ONLY ONE BOX)  Actively Employed  Retired

**VII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION**

**IF YOU HAVE OTHER COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.**

Check this block if any person listed on this Form is now or has been enrolled within the last 31 days in health care or catastrophic coverage through a Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization, another insurance carrier or Medicaid. 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 \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Name and Location of Insurance Company \_\_\_\_\_

3. Policy Number \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Policy Covers  Policy Holder Only  Two Persons  Family

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

Employer/Group Name \_\_\_\_\_

6. Services Covered:
- |                                |                              |                             |
|--------------------------------|------------------------------|-----------------------------|
| A. Hospital                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Physician                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Out-of-pocket Major Medical | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Separate Drug Program       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Dental                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Eye or Vision Care          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Mental Illness              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**VIII. PLEASE READ CAREFULLY - THIS SECTION MUST BE DATED AND SIGNED**

**IT IS UNDERSTOOD AND AGREED THAT:**

- (a) I am applying for enrollment with CareFirst BlueChoice, Inc. for myself and for any eligible dependents listed.
- (b) The statements and answers made herein are complete and correct to the best of my knowledge and belief, and are made to cause the issuance of, and to become a part of, the coverage for which I am applying. Should any statement or answers made herein change before the coverage becomes effective I will promptly notify CareFirst BlueChoice, Inc.
- (c) Coverage will become effective according to your Group's eligibility guidelines following approval of this Form by CareFirst BlueChoice, Inc.
- (d) If I furnish CareFirst BlueChoice, Inc. with incorrect or incomplete information which is material to the acceptance of this Form, CareFirst BlueChoice, Inc. may terminate my coverage at any time, retroactive to my initial effective date. In this case, CareFirst BlueChoice, Inc.'s obligation shall consist only of the return of any subscription charges actually paid, less the amount of any benefits paid. However, after the Agreement has been in force for 2 years, CareFirst BlueChoice, Inc. may rescind my coverage only for nonpayment of premium.
- (e) The Subscriber shall repay to CareFirst BlueChoice, Inc. the amount of any payment(s) made in error to the Subscriber or on the behalf of the Subscriber or any covered family member as the result of a claim.
- (f) A copy of this Form is available to the Subscriber (or a person authorized to act on his behalf) upon request.

**NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under the coverage for which you are applying, please contact a membership service representative before signing this Form.**

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of Applicant Date Signature of Applicant Date