

Application for BlueChoice Opt-Out *Plus* Coverage (Maryland Groups)

BlueChoice Opt-Out *Plus* is a dually offered product with in-network benefits provided by CareFirst BlueChoice, Inc. and out-of-network benefits by CareFirst BlueCross BlueShield.

HOW TO COMPLETE THIS APPLICATION:

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 application to your Employer.
5. **Employer must complete if Section VI is answered.** Number of employees in group.

I. APPLICANT			
Last Name	First Name	Initial	Social Security Number
Residence Address (<i>Number and Street</i>) (<i>City and State</i>)			Home Phone ()
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widow(er)	Height/Weight
Employed By (<i>Firm Name</i>)		Address	Group Number Work Phone ()
Occupation		Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Date Employed / /
Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Primary Dental Office		Dental Office Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
II. TYPE OF ENROLLMENT		IV. CHANGE TO EXISTING COVERAGE	
CHECK ONE: <input type="checkbox"/> New <input type="checkbox"/> Coverage Change		Dependents affected by adds or deletes must be listed in Section V - Dependent Information Identification Number, if different from Social Security Number _____ <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 adoption on _____ (Date) or appointed legal guardian by court decree dated _____. (Note: Documentation of adoption or court-appointed legal guardianship must be provided.) <input type="checkbox"/> REMOVE dependent(s) due to _____ _____ (Reason) _____ (Date) <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	
III. TYPE OF COVERAGE			
CHECK ONE: <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"/> Is coverage complementary to Medicare? If so, complete Section VI, Medicare Coverage.			

V. DEPENDENT INFORMATION

1 Spouse	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Primary Dental Office		Dental Office Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
2 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Primary Dental Office		Dental Office Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
3 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Primary Dental Office		Dental Office Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
4 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Primary Dental Office		Dental Office Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
5 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Primary Dental Office		Dental Office 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	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 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 _____ 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 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 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 _____ Policy Covers: Policy Holder Only Two-Persons Family

4. Effective Date of Policy: _____/_____/_____
month day year

5. Service(s) Covered:

- | | | | |
|---|--|-----------------------------|--|
| A. Hospital Services | <input type="checkbox"/> Yes <input type="checkbox"/> No | E. Dental | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. Physician Services | <input type="checkbox"/> Yes <input type="checkbox"/> No | F. Eye/Vision Care Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Major Medical (out-of-pocket expenses) | <input type="checkbox"/> Yes <input type="checkbox"/> No | G. Mental Illness Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. Separate Drug Program | <input type="checkbox"/> Yes <input type="checkbox"/> No | H. HMO | <input type="checkbox"/> Yes <input type="checkbox"/> 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 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 / Child's Date of Birth

Relationship to Child / Child's Name

PARENT WITH CUSTODY OF CHILD(REN)

Parent's Name / Child's Date of Birth

Relationship to Child / Child's Name

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. I understand that BlueChoice Opt-Out *Plus* is a dually offered product with in-network benefits provided by CareFirst BlueChoice, Inc. and out-of-network benefits provided by CareFirst BlueCross BlueShield.
- (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 application by CareFirst BlueChoice, Inc.
- (d) If I furnish CareFirst BlueChoice, Inc. with incorrect or incomplete information which is material to the acceptance of this application, CareFirst BlueChoice, Inc. may rescind my coverage at any time, retroactive to my initial effective date. However, after the Agreement has been in force for two years, CareFirst BlueChoice, Inc. may rescind my coverage only for fraudulent misstatements. In either case, CareFirst BlueChoice, Inc. obligation shall consist only of the return of any subscription charges actually paid, less the amount of any benefits paid.
- (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.

VIII. PLEASE READ CAREFULLY -- THIS SECTION MUST BE DATED AND SIGNED (Continued)

- (f) If this application is approved by CareFirst BlueChoice, Inc., I authorize any Provider to forward to CareFirst BlueChoice, Inc. information concerning medical, surgical, psychiatric or psychological services or supplies provided to me or to any of my dependents listed on this application for the purpose of review, investigation or payment of a claim. This authorization is valid for the duration of coverage.
- (g) A copy of this application 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 services representative before signing this application.

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