



550 12th Street, SW * Washington DC 20065

CareFirst BlueChoice, Inc. Enrollment Information Form

1. APPLICANT

Social Security Number		Group Number	
Name – Last, First, Middle		Home Phone	Work Phone
Address – Number and Street		City	State Zip Code
Employed By	Occupation	Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Date Employed / /
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> (Other) _____		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Name of Primary Care Physician		Physician Code #	

II. TYPE OF ENROLLMENT

CHECK ONE:
 New Coverage Change

III. TYPE OF COVERAGE

CHECK ONE:
 Self-only coverage
 Self and spouse (Two party)
 Self and child (Two party)
 Family
 Coverage complementary to Medicare (self-only)

IV. CHANGE TO EXISTING COVERAGE

Dependents affected by adds or deletes must be listed in dependent information in Section V below.
 Identification number, if different from Social Security Number _____
 Add Family Member(s) listed in Section V below
 Add Spouse due to marriage on _____ (date)
 Add Child due to adoption on _____ (date) or appointed legal guardian by court decree dated _____.
 Documentation required if adoption proceedings are underway or you are court-appointed legal guardian. (CareFirst will pay the cost for documentation)
 Remove Family Member(s) due to _____ (reason) on _____ (date)
 Change address to that shown in Section I above
 Change my name from _____ to that shown in Section I above
 Change Primary Care Physician to that shown in Section V below for dependent or Section I for applicant.

V. DEPENDENT INFORMATION

1	SPOUSE	Name – (Last, First, MI)	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician			Physician Code #	
2	CHILD	Name – (Last, First, MI)	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician			Physician Code #	
3	CHILD	Name – (Last, First, MI)	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician			Physician Code #	
4	CHILD	Name – (Last, First, MI)	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician			Physician Code #	

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

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

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 Disabled Kidney disease
 Medicare Claim No. _____ Eligible for Part A effective _____ Eligible for Part B effective _____

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 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 _____ 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 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 terminate my coverage at any time, retroactive to my initial effective date. In this case, CareFirst BlueChoice, Inc. 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 two years, CareFirst BlueChoice, Inc. may terminate my coverage only for the nonpayment of premiums.
- (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) Any physician, nurse, hospital or other provider (hereafter "Provider") having treated or attended me or any of my family members listed on this application, and having possession of any records or information with respect thereto, is authorized and directed to provide such information or records to CareFirst BlueChoice, Inc. upon request for the purpose of evaluation of this application. This authorization is valid for 30 months.
- (g) 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.
- (h) 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 service representative before signing this application.

X _____
DATE

X _____
DATE

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 CareFirst BlueChoice Physician Directory. **Failure to provide this information may delay in-network services.**
- 4. Please return your Enrollment Information Form to your Employer.
- 5. **Employer must complete if Section VI is answered.** Number of employees in group _____ .

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