



Enrollment Transaction Report

Please Print All Information

Group Number:	Date:	

Group Name: _____

Group Location:	DC 🗆	MD 🗆	VA		OTHER	
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Group Administrator: _____

ATTENTION: APPLICATIONS MUST BE INCLUDED WITH ALL ADDITIONS, REINSTATEMENTS AND CHANGES IN COVERAGE

Group Administrator Phone Number: _____

Check Appropriate Column

NAME	SOCIAL SECURITY NUMBER	ADD	DELETE	CHANGE	EFFECTIVE DATE	REMARKS	FOR INTERNAL USE ONLY IACS NUMBER

Please return this form to:

CareFirst BlueCross BlueShield/CareFirst BlueChoice, Inc. 840 First Street, NE Washington, DC 20065 Attention: Account Implementation Department

Mailstop 31

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CUT5795-1S (6/03)