CareFirst BlueChoice

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

CareFirst BlueChoice, Inc. Enrollment Form

(District of Columbia 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 _____

Medical Option_____ Dental Option_____

Effective Date Requested / /

Vision Option_____

Social Security Number

Date of Birth / /

Sex ☐ Male ☐ Female

Last Name First Name Initial

Date of Hire / /

Occupation

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired

Residence Address *(Number and Street)* *(City and State)* *(Zip Code-9 digit, if known)*

Home Phone ( )

Work Phone ( )

Marital Status ☐ Single ☐ Married ☐ Other ☐ Legally Separated ☐ Widow(er)

Height /Weight

Name of Primary Care Physician

Physician Code #

Current Patient ☐ Yes ☐ No

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)

COVERAGE SELECTED: Check only those options that your employer has elected to offer.

☐ BlueChoice
☐ BlueChoice Opt-Out

☐ Dental HMO
☐ Dental HMO Opt-Out
☐ Preferred Dental
☐ Traditional Dental
☐ BlueVision *Plus*

IV. CHANGE TO EXISTING COVERAGE

Dependents affected by adds or deletes must be listed in Section V - Dependent Information

Identification Number, if different from Social Security Number

_____

☐ *ADD* dependent(s) listed in Section V

☐ *ADD* spouse due to marriage on_____(Date)

☐ *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.)

☐ *REMOVE* dependent(s) listed in Section V due to_____

_____(Reason)_____(Date)

☐ *CHANGE* address to that shown in Section I above

☐ *CHANGE* my name from_____ to that shown in Section I

☐ *CHANGE* Primary Care Physician to that shown in Section I for applicant and Section V for dependent

V. DEPENDENT INFORMATION

1	**Spouse**	Name - (Last, First, MI)	Social Security No.	Date of Birth	Sex ☐ Male ☐ Female	Height /Weight
		Name of Primary Care Physician		Physician Code #		Current Patient ☐ Yes ☐ No
2	**Child**	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex ☐ Male ☐ Female	Height /Weight
		Name of Primary Care Physician		Physician Code #		Current Patient ☐ Yes ☐ No
3	**Child**	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex ☐ Male ☐ Female	Height /Weight
		Name of Primary Care Physician		Physician Code #		Current Patient ☐ Yes ☐ No
4	**Child**	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex ☐ Male ☐ Female	Height /Weight
		Name of Primary Care Physician		Physician Code #		Current Patient ☐ Yes ☐ No

COMPLETE ONLY IF DEPENDENT CHILD LISTED ABOVE IS AGE 19 OR OVER

Dependent Name - (Last, First, MI)	Full-Time Student? ☐ Yes ☐ No	**IF YES, ATTACH STUDENT CERTIFICATION FORM**	Disabled? ☐ Yes ☐ No	**IF YES, ATTACH DISABILITY CERTIFICATION FORM AND SUPPORTING DOCUMENTATION**
Dependent Name - (Last, First, MI)	Full-Time Student? ☐ Yes ☐ No		Disabled? ☐ Yes ☐ 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	☐ Yes	☐ No
B. Physician	☐ Yes	☐ No
C. Out-of-pocket Major Medical	☐ Yes	☐ No
D. Separate Drug Program	☐ Yes	☐ No
E. Dental	☐ Yes	☐ No
F. Eye or Vision Care	☐ Yes	☐ No
G. Mental Illness	☐ Yes	☐ No

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

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this Form is accepted, coverage will be provided according to the terms and conditions of the contract between CareFirst BlueChoice, Inc. and my employer. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

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, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I have carefully read this Form and agree to its terms. The recorded answers on this Form are, to the best of my knowledge and belief, full, complete and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your Form and/or claims payment.

X _____ **X** _____

Date **Signature of Applicant**