ENROLLMENT FORM
WITH A HEALTH QUESTIONNAIRE
(District of Columbia Groups)

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

1 EMPLOYER INFORMATION: To be completed by the employer.

Employer/Group Administrator

Group Number:

Medical: ______________________ Dental: ______________________

Effective Date Requested __ __/__ __/__ __

Medical Option: ____________________ Vision: __________________

Check all that apply

Employment Status ☐ Active ☐ Full Time ☐ Part Time ☐ Retired

2 TYPE OF REQUEST

☐ New Subscriber ☐ Coverage Change ☐ Add Dependents ☐ Delete Dependents

☐ Any information change (name or address change)

Are you enrolling eligible dependents? ☐ Yes ☐ No

3 SUBSCRIBER INFORMATION

Social Security Number	Subscriber Last Name	First Name	Middle Initial
__ __ __ - __ __ - __ __ __ __			

Date of Birth	Sex:	Date of Hire:	Marital Status:
__ __/__ __/__ __	☐ Male ☐ Female	__ __/__ __/__ __	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Effective Date of Marital Status __ __/__ __/__ __

Street Address	Apt.	City	County	State

Country	Zip	Home Phone	Work Phone
		( ) __ __ __ - __ __ __ __	( ) __ __ __ - __ __ __ __

4 CHANGE TO EXISTING COVERAGE

Dependents affected by adds or deletes must be listed in Section 5 Dependent Information.

Identification Number, if different from Social Security Number ____________________________

☐ *ADD* dependent(s) listed in Section 5

☐ *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. CareFirst BlueCross BlueShield will pay the cost of the documentation required to provide proof of adoption or court-appointed legal guardianship.)

☐ *REMOVE* dependent(s) listed in Section 5 due to ____ (Reason)

_______________________ (Date)

☐ *CHANGE* address to that shown in Section 3 above

☐ *CHANGE* my name from ____ to that shown in Section 3

5 SUBSCRIBER & DEPENDENT INFORMATION: Please list all persons to be covered.

COVERAGE LEVEL – Please confirm with your employer the details of the benefit options offered by your employer prior to completing this section to avoid delays in processing this Enrollment Form.

COVERAGE LEVELS OF SUBSCRIBER AND DEPENDENTS, IF APPLICABLE

Coverage Level for Medical Option (if applicable and your employer has elected to offer):

☐ Self ☐ Self and Child ☐ Self and Spouse ☐ Family ☐ Coverage Complementary to Medicare (self-only)

Coverage Level for Dental Option (if applicable and your employer has elected to offer):

☐ Self ☐ Self and Child ☐ Self and Spouse ☐ Family

Coverage Level for BlueVision Plus Option (if applicable and your employer has elected to offer):

☐ Self ☐ Self and Child ☐ Self and Spouse ☐ Family

SUBSCRIBER INFORMATION

Last	First	MI	Coverage Level	Relationship	Sex	Height	Weight	Date of Birth	Social Security Number
			☐ Medical ☐ Traditional Dental ☐ Preferred Dental ☐ BlueVision *Plus*	Subscriber					

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5 SUBSCRIBER & DEPENDENT INFORMATION (continued)

DEPENDENT INFORMATION: If the subscriber has more than four dependents, please list the additional dependents on a separate Enrollment Form.

Last	First	MI	Coverage Level	Relationship	Sex	Height	Weight	Date of Birth	Social Security Number
			☐ Medical ☐ Dental ☐ BlueVision *Plus*						
			☐ Medical ☐ Dental ☐ BlueVision *Plus*						
			☐ Medical ☐ Dental ☐ BlueVision *Plus*						
			☐ Medical ☐ Dental ☐ BlueVision *Plus*						

Is anyone listed above a student or disabled? ☐ YES ☐ NO

If the answer is YES, please list the name of the person ____

If a full-time student, please attach student certification form. If yes, disabled, please attach disability certification form and supporting documentation.

6 MEDICARE INFORMATION: To be completed if applicable.

		Medicare Number	Hosp. Eff. Date (Part A)	Med. Eff. Date (Part B)
Are You Eligible for Medicare?	☐ Yes ☐ No	If Yes: _ _ _ - _ _ - _ _ _ _ _ - _ _	_ _/_ _/_ _	_ _/_ _/_ _

Reason for Entitlement: ☐ Age 65 or older ☐ End Stage Renal Disease ☐ Disabled

		Medicare Number	Hosp. Eff. Date (Part A)	Med. Eff. Date (Part B)
Spouse?	☐ Yes ☐ No	If Yes: _ _ _ - _ _ - _ _ _ _ _ - _ _	_ _/_ _/_ _	_ _/_ _/_ _

Reason for Entitlement: ☐ Age 65 or older ☐ End Stage Renal Disease ☐ Disabled

		Medicare Number	Hosp. Eff. Date (Part A)	Med. Eff. Date (Part B)
Child/Dependent?	☐ Yes ☐ No	If Yes: _ _ _ - _ _ - _ _ _ _ _ - _ _	_ _/_ _/_ _	_ _/_ _/_ _

Reason for Entitlement: ☐ Age 65 or older ☐ End Stage Renal Disease ☐ Disabled

7 OTHER HEALTH INSURANCE INFORMATION

IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

Is any person listed on the enrollment form covered by another health care plan, HMO, or Medicare? ☐ Yes ☐ No

If yes, will this coverage be continued? ☐ Yes ☐ No If no, please provide the cancellation date _ _/_ _/_ _

Policyholder's Name	Phone Number of Other Insurer	Date of Birth
	( ) _ _ _ - _ _ _ _	_ _/_ _/_ _

Name and Address of Insurance Company

Policy Number	Termination Date	Effective Date of Policy
	_ _/_ _/_ _	_ _/_ _/_ _

Services Covered: ☐ Hospital Services ☐ Physician Services ☐ Major Medical ☐ Drug Program ☐ Dental Services ☐ Eye/Vision Care Services ☐ HMO ☐ Mental Illness Services

Does this policy cover you? ☐ Yes ☐ No Your spouse? ☐ Yes ☐ No Your children? ☐ Yes ☐ No

Please list name(s) of children covered ____

Is this coverage under COBRA? ☐ Yes ☐ No If yes, reason for cancellation ______________________________

____ Cancellation Date _ _/_ _/_ _

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8 HEALTH QUESTIONNAIRE

NOTE: Check with your Group Administrator before you complete Sections A, B, and C. This information may not be required.

SECTION A - CHECK EACH ITEM YES OR NO (If confidentiality is desired, please make arrangements with your Group Administrator.) To the best of your knowledge and belief, has any person named in this Enrollment Form had within the last seven years or does such person now have, any of the following?

YES	NO	
☐	☐	(a) Cancer, tumor or other growth, (malignant or benign)
☐	☐	(b) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test)
☐	☐	(c) Kidney stones, kidney or bladder condition, urinary frequency or burning
☐	☐	(d) Goiter, thyroid condition, diabetes
☐	☐	(e) Seizure disorder, central nervous system disorder, multiple sclerosis
☐	☐	(f) Substance abuse (drug or alcohol dependency, abuse or addiction)
☐	☐	(g) Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition
☐	☐	(h) Cataract or other eye condition
☐	☐	(i) Tuberculosis, lung condition, asthma, bronchitis
☐	☐	(j) Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition
☐	☐	(k) Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)
☐	☐	(l) (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition
☐	☐	(m) (Female) Is currently pregnant; expected date of delivery: ____/____/____
☐	☐	(n) (Male) Prostate condition, reproductive system disorders, infertility
☐	☐	(o) Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder
☐	☐	(p) Sexually transmitted diseases
☐	☐	(q) Anemia, blood disorders

SECTION B - In addition to the conditions listed in **SECTION A**, to the best of your knowledge and belief, within the past five years, has any person named in this Enrollment Form:

YES	NO	
☐	☐	(a) Had a physical examination?
☐	☐	(b) Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or reason for prescription medication **not** listed in **SECTION A**?
☐	☐	(c) Had any departure from good health **not** previously mentioned in any of the above questions for which treatment or advice may or may not have been sought?

SECTION C — If you have checked "YES" to any part of SECTION A or SECTION B, for each block checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgery and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Patient's First Name	Section & Letter	Diagnosis or Condition	Duration Dates FROM:	TO:	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician's/hospital's name.	Recovery Check only one box.
						☐ FULL ☐ PARTIAL
						☐ FULL ☐ PARTIAL
						☐ FULL ☐ PARTIAL
						☐ FULL ☐ PARTIAL

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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 BlueCross BlueShield 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. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your enrollment for coverage.

___________________________________ __ __/__ __/__ __

Subscriber's Signature Date

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