ENROLLMENT FORM
WITH A HEALTH QUESTIONNAIRE
(Virginia Groups)

CareFirst BlueCross BlueShield
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: _____

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: ☐ Male ☐ Female

Date of Hire: __ __/__ __/__ __

Marital Status: ☐ 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					

CUT5152-4S (7/04)

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			
Spouse?	☐ Yes ☐ No	If Yes: __ __ __ - __ __ - __ __ __ __ - __ __	__ __/__ __/__ __	__ __/__ __/__ __
	Reason for Entitlement: ☐ Age 65 or older ☐ End Stage Renal Disease ☐ Disabled			
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 __ __/__ __/__ __

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

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