Individual CareFirst BlueChoice, Inc. Application

(District of Columbia Residents)

OFFICE USE ONLY:	
ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

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

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Be sure to select a **Primary Care Physician (PCP) and PCP ID number** for all enrolled applicants.
3. Sign and return this application in the postage-paid return envelope.

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If incomplete, the application will be returned and delay your coverage.***

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security Number

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

Billing Address, if different from Residence Address: (Number and Street)	(City and State)	(Zip Code—9 digit, if known)

Date of Birth	Sex	Marital Status	Height	Weight
/ /	☐ Male ☐ Female	☐ Married ☐ Single		

Home Phone	Work Phone	E-mail Address
( )	( )	

Name of Primary Care Physician (PCP)	PCP ID Number

2. COVERAGE

TYPE OF COVERAGE ELECTED (CHECK ONE):

☐ Self-Only ☐ Two-Party (Subscriber and Spouse) ☐ Two-Party (Subscriber and Child) ☐ Family

(**NOTE**: Section 3 must be completed if enrolling for Two-Party or Family Coverage)

COVERAGE LEVEL DESIRED:

CHECK ONE:	PCP/Specialist Copay	Inpatient Hospital	Prescription Drug
☐	$20/$30	$700 per admission	$150 deductible, $10/$25/$40, $500 max
☐	$15/$25	$500 per admission	$100 deductible, $10/$25/$40, $1000 max
☐	$10/$20	$250 per admission	$50 deductible, $10/$25/$40, $1000 max

MATERNITY BENEFITS:
Check here if you wish to include benefits for maternity services. ☐ Yes

DENTAL BENEFITS: Check here if you wish to include benefits for dental services. ☐ Yes

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:			
Sub-Agent/Sub-Agency:			
Writing Agent:			

3. ENROLLING FAMILY MEMBER(S) *List all to be covered.*

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	M or F	HT (in.)	WT (lbs.)	**Medical Center or PCP Name (Include PCP ID #)**
Spouse									Name PCP ID #
Dependent 1									Name PCP ID #
Dependent 2									Name PCP ID #
Dependent 3									Name PCP ID #
Dependent 4									Name PCP ID #

4. OTHER INSURANCE INFORMATION

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

YES **NO**

1. Is anyone listed on this application eligible for Medicare? . . . . . ☐ ☐

   If yes, please provide the following:

   Name of family member(s) _____ Medicare No. _____ Effective Date _____

2. Is anyone listed on this application covered by other health insurance, including other Blue Cross Blue Shield coverage? . . . . . ☐ ☐

   If yes, please provide the following:

   Name of family member(s) _____ Insurance Company _____

   Policy Number and Type _____ Effective Date _____

   If you are accepted, will your new CareFirst BlueChoice coverage replace your existing policy? . . . . . ☐ ☐

3. Has anyone listed on this application been without health insurance for the past 12 months or longer? . . . . . ☐ ☐

   If yes, please list name(s): _____

5. HEALTH EVALUATION

PLEASE COMPLETE SECTIONS A AND B. CHECK EACH ITEM YES OR NO. Answering yes will not necessarily result in the rejection of your application.

YES **NO**

Have you or any family member named in the accompanying application had a physical examination within the past 5 years? . . . . . ☐ ☐

SECTION 5A — Has any person included on this application had any known indication, diagnosis or treatment within the last 5 years of any of the conditions listed below?

YES **NO**

1. Cancer, tumor or other growth, (malignant or benign) . . . . . ☐ ☐
2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test) . . . . . ☐ ☐
3. Kidney stones, kidney or bladder condition, urinary frequency or burning . . . . . ☐ ☐

5. HEALTH EVALUATION CONTINUED…

	YES	NO
4. Goiter, thyroid condition, diabetes	☐	☐
5. Seizure disorder, central nervous system disorder, multiple sclerosis	☐	☐
6. Substance abuse (drug or alcohol dependency, abuse or addiction)	☐	☐
7. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	☐	☐
8. Cataract or other eye condition	☐	☐
9. Tuberculosis, lung condition, asthma, bronchitis	☐	☐
10. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	☐	☐
11. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)	☐	☐
12. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition	☐	☐
13. (Female) Is currently pregnant; expected date of delivery: ____/____/____	☐	☐
14. (Male) Prostate condition, reproductive system disorders, infertility	☐	☐
15. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	☐	☐
16. Sexually transmitted diseases	☐	☐
17. Anemia, blood disorders	☐	☐
18. 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 prescription medication for a medical condition NOT listed above in items 1-17?	☐	☐
19. Had any departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought?	☐	☐
20. Has any person on this application received any other medical or surgical advice or treatment or hospital care in the past 5 years?	☐	☐

SECTION 5B — If you have checked "YES" to any part of SECTION 5A, for each block checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

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

NOTE: FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN VOIDING OF MEMBERSHIP AND DENIAL OF BENEFITS.

(over, please)

6. CONDITIONS OF ENROLLMENT — (Please Read This Section Carefully)

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request. If this application is accepted by BlueChoice, a copy of this application will be attached to the contract issued to the Subscriber.

This information is subject to verification. Failure to complete any section may delay the processing of your application 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 application for coverage.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a BlueChoice policy. I understand that a medically underwritten policy is only issued under the conditions that the health of all persons named on the application remains as stated above. I also understand that failure to enter accurate, complete and updated medical information may result in the denial of all benefits, cancellation or voiding of my policy.

I will update BlueChoice if there have been any changes in health concerning any person listed in this application that occurs prior to acceptance of this application by BlueChoice.

IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY OR EXCLUDED UNDER THIS AGREEMENT, PLEASE CONTACT A MEMBERSHIP SERVICES REPRESENTATIVE BEFORE SIGNING THIS APPLICATION.

It is a fraudulent insurance act for a person to knowingly or willfully make a false or fraudulent statement or representation in or with reference to an application of insurance.

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.

Signature of Applicant 1:* X_____ Date:_____

Signature of Applicant 2: X_____ Date:_____

☐ Re-sign and re-date below **only** if block is checked.

Signature of Applicant 1: X_____ Date:_____

Signature of Applicant 2: X_____ Date:_____

* Rates are based on the age of the oldest applicant.