Individual CareFirst BlueChoice, Inc. HIPAA 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
/ /	☐ 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	Maternity Option
☐ **Low Option**	$20/$30	$700 per admission	$150 deductible, $10/$25/$40, $500 max	Not Included
☐ **High Option**	$10/$20	$250 per admission	$50 deductible, $10/$25/$40, $1000 max	Included

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	**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. CREDITABLE COVERAGE INFORMATION

	YES	NO
1. Are you eligible for coverage under any group health benefits plan or employer sponsored health benefits plan?	☐	☐
2. Are you eligible or entitled to Medicare Part A or Part B?	☐	☐
If yes, please state your Medicare Number _____		
3. Are you eligible for Medicaid, or any similar state plan under Title XIX of the Social Security Act?	☐	☐
4. Are you currently covered under any other health benefit plan?	☐	☐
If yes, please state the name and address of the insurer or health plan _____		
the policy or group number _____		
your identification number(s) _____		
5. Were your prior health benefits terminated because of nonpayment of the premium or subscription charges by the applicant when due?	☐	☐
6. Were your prior health benefits terminated for reasons of a fraudulent act by the applicant?	☐	☐
7. Federal law requires that a group health plan sponsored by an employer who regularly employs 20 or more employees offer employees and their families the opportunity for a temporary extension of health coverage called **Continuation Coverage (or COBRA coverage)**. This Continuation Coverage is offered for a specific number of months depending on the applicant's situation. The employer or Plan Administrator will be able to tell an applicant how many months of Continuation Coverage is available.		
If you were offered this Continuation Coverage, did you refuse this coverage or elect to terminate this coverage before the end of the allowed Continuation Coverage period?	☐	☐

INSTRUCTIONS:

An applicant who has not been covered under any health benefits plan for a period of more than 63 consecutive days within the last eighteen months, or who has answered "Yes" to any of the questions in Section 5, Creditable Coverage, must complete a Medically Underwritten Application. To obtain this application, please call (410) 356-8000 or (800) 544-8703.

NOTE: An applicant's prior insurer or health plan, if any, is required by federal law to provide a Certificate of Coverage that indicates how many months the applicant has been continuously covered under "creditable coverage", as defined under federal law. **Please attach all Certificates of Coverage to this application**. Retain a copy for your records.

If an applicant has a Certificate of Coverage that states: 1) that an applicant has 18 months of continuous creditable coverage; 2) whose most recent prior creditable coverage was under an employer sponsored plan, Medicare, Medicaid, or any program sponsored by the government, a church plan, or any health benefit plan offered in connection with these plans; and, 3) the applicant answered all of the above questions with "NO", then the applicant will not need to request the Medically Underwritten Application.

NOTE: An applicant who cannot obtain a Certificate of Coverage can provide written documentation from an employer or health plan showing creditable coverage. Such applicants are encouraged to call CareFirst BlueChoice, Inc. prior to submitting this additional information with this application.

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 CareFirst BlueChoice, Inc. (hereafter "BlueChoice"), a copy of this application will be attached to the contract issued to the Subscriber.

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. Failure to provide complete and accurate information on this application may result in voiding any policy issued on the inaccurate information.

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.

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:_____

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