Individual BluePreferred Application

(District of Columbia Residents)

OFFICE USE ONLY:

ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

CareFirst BlueCross BlueShield

Group Hospitalization and Medical Services, 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. 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	☐ Single ☐ Married		

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

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)	DEDUCTIBLE (In-Network)	DEDUCTIBLE (Out-of-Network)	COVERAGE LEVEL (In-Network)	COVERAGE LEVEL (Out-of-Network)	OUT-OF-POCKET LIMIT (In-Network)	OUT-OF-POCKET LIMIT (Out-of-Network)
☐	$ 100	$ 300	90%	70%	$2,500	$5,000
☐	$ 300	$ 600	90%	70%	$2,500	$5,000
☐	$ 300	$ 600	80%	60%	$2,500	$5,000
☐	$ 500	$1,000	80%	60%	$2,500	$5,000
☐	$ 750	$1,500	80%	60%	$3,500	$7,000
☐	$2,500	$5,000	80%	60%	$5,000	$7,500

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

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

6. 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.

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

☐ Yes ☐ No

SECTION A — To the best of your knowledge or belief, has any person named in this application had within the last 5 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), 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, amputations(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	☐	☐
(r) 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 A-Q?	☐	☐
(s) Had any departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought?	☐	☐

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

(over, please)

3. ENROLLING FAMILY MEMBERS (Complete only if you select Two-Party or Family Coverage)

LAST NAME	FIRST NAME AND MIDDLE INITIAL	RELATIONSHIP	SOCIAL SECURITY NO.	DATE OF BIRTH Month Day Year	SEX	HEIGHT	WEIGHT
			- -		☐M ☐F		
			- -		☐M ☐F		
			- -		☐M ☐F		
			- -		☐M ☐F		
			- -		☐M ☐F		
			- -		☐M ☐F		

4. MEDICARE COVERAGE

☐ Check this block if any persons listed on this application are eligible for or are receiving benefits under Medicare.
If you checked the block, please give:

Name: _____ Medicare Claim No.: _____

Eligible for: ☐ Part A (Hospital Insurance) Eff. Date _____/_____/_____

☐ Part B (Medical Insurance) Eff. Date _____/_____/_____

Reason for entitlement: ☐ Age 65 or older ☐ End stage renal disease ☐ Disabled

Beginning date of renal treatment, if applicable: _____/_____/_____

Name: _____ Medicare Claim No.: _____

Eligible for: ☐ Part A (Hospital Insurance) Eff. Date _____/_____/_____

☐ Part B (Medical Insurance) Eff. Date _____/_____/_____

Reason for entitlement: ☐ Age 65 or older ☐ End stage renal disease ☐ Disabled

Beginning date of renal treatment, if applicable: _____/_____/_____

5. OTHER COVERAGE

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

5a. ☐ Check this block if any person listed on this application 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, or another insurance carrier or Medicaid. Is this coverage in effect? ☐ Yes ☐ No

5b. If Yes, will this coverage be continued? ☐ Yes ☐ No If No, please provide cancellation date _____/_____/_____
Reason for cancellation? _____

If you answered "Yes" to question 5a, please complete the following.

1. Policy Holder's Name: _____ Sex: ☐ M ☐ F Date of Birth _____/_____/_____
2. Name and Location of Insurance Company: _____
3. Policy Number: _____ Policy covers: ☐ Policy Holder Only ☐ Two-Party ☐ Family
4. Effective Date of Policy: _____/_____/_____
5. Service(s) Covered:

A. Hospital Services	☐ Yes	☐ No	E. Dental	☐ Yes	☐ No
B. Physician Services	☐ Yes	☐ No	F. Eye/Vision Care Services	☐ Yes	☐ No
C. Major Medical (out-of-pocket expenses)	☐ Yes	☐ No	G. HMO	☐ Yes	☐ No
D. Separate Drug Program	☐ Yes	☐ No	H. Maternity Services	☐ Yes	☐ No

6. Is coverage through an employer or other group? ☐ Yes ☐ No
If Yes, name of employer or other group: _____
7. Is coverage through an individual insurance policy? ☐ Yes ☐ No

7. HEALTH EVALUATION QUESTIONS CONTINUED...

SECTION B — If you have checked "YES" to any part of SECTION A, 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	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

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

IT IS UNDERSTOOD AND AGREED THAT:

(a) The contract will become effective on the first day of the month following final approval of the application by Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield (hereafter "CareFirst") or as determined by CareFirst.

(b) The Subscriber shall repay to CareFirst the amount of any payment(s) made in error to the Subscriber or on behalf of the Subscriber or any covered family member as the result of a claim.

(c) 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, 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 CareFirst policy. I understand that a medically underwritten policy is only issued under the condition 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 benefits, cancellation or voiding of my policy.

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: **X**_____ Date:_____

☐ Re-sign and re-date below **only** if block is checked.
Signature of Applicant: **X**_____ Date:_____