Individual BluePreferred HIPAA Application

(District of Columbia Residents)

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

OFFICE USE ONLY:

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

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 your coverage will be delayed.

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 ☐ Male ☐ Female	Marital Status ☐ 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)

PLEASE SELECT ONE OF THE OPTIONS LISTED BELOW

☐ **HIGH OPTION**	☐ **LOW OPTION**
$100 In-Network Deductible	$300 In-Network Deductible
$300 Out-of-Network Deductible	$600 Out-of-Network Deductible
10% In-Network Member Coinsurance	20% In-Network Member Coinsurance
30% Out-of-Network Member Coinsurance	40% Out-of-Network Member Coinsurance
Maternity Included	Maternity Excluded
Prescription Drug	Prescription Drug

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

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

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
			- -				☐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. OTHER COVERAGE (CONTINUED)

5. Service(s) Covered:

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

6. HIPAA ELIGIBILITY

1. Is any applicant eligible for coverage under any group health benefits plan or employer sponsored health benefits plan? ☐ Yes ☐ No
   If yes, please state the name of the applicant(s)______________________________
2. Is any applicant eligible or entitled to Medicare, Part A or Part B? ☐ Yes ☐ No
   If entitled, please state the name of the applicant(s)______________________________
   and the applicant's Medicare Number(s)______________________________
3. Is any applicant eligible for Medicaid, or any similar state plan under Title XIX of the Social Security Act? ☐ Yes ☐ No
   If yes, please state the name of the applicant(s)______________________________
4. Is any applicant currently covered under any other health benefit plan? ☐ Yes ☐ No
   If yes, please state the name of the applicant(s)______________________________
   the date of birth of the applicant(s)______________________________
   the name and address of the insurer or health plan(s)______________________________
   the policy or group number(s)______________________________
   ____
   the applicant's identification number(s)______________________________
5. Was any applicant's prior health benefits plan terminated because of nonpayment of the premium or subscription charges by the applicant when due? ☐ Yes ☐ No
   If yes, please state the name of the applicant(s)______________________________
6. Was any applicant's prior health benefits plan terminated for reasons of a fraudulent act by the applicant? ☐ Yes ☐ No
   If yes, please state the name of the applicant(s)______________________________

   Federal law requires that a group health plan sponsored by an employer who regularly employs 20 or more employees offers 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.

7. If any applicant was offered this Continuation Coverage, did that applicant refuse this coverage or elect to terminate this coverage before the end of the allowed Continuation Coverage period? ☐ Yes ☐ No
   If yes, please state the name of the applicant(s)______________________________

6. HIPAA ELIGIBILITY (CONTINUED)

8. During the past 18 months has any applicant lost coverage under any health benefits plan for a period of 63 consecutive days or more? ☐ Yes ☐ No

If you have answered NO to all of the questions above, then under State and Federal law you are eligible for this coverage without medical underwriting, and pre-existing condition waiting periods.

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.

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 BlueCross BlueShield prior to submitting this additional information with this application.

7. 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.

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 Bluecross BlueShield 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: **X**____________________________________ Date:____________________