# Individual BluePreferred Application

(Virginia 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 delay your coverage.*

## TYPE OF ENROLLMENT (CHECK ONE)

☐ Underwritten ☐ Underwritten (First choice) or HIPAA (Second choice)
☐ HIPAA

## 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:**

| | DEDUCTIBLE | | COVERAGE LEVEL | | OUT-OF-POCKET LIMIT | |
|---|---|---|---|---|---|---|
| **(CHECK ONE)** | (In-Network) | (Out-of-Network) | (In-Network) | (Out-of-Network) | (In-Network) | (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: | | | |

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 | HEIGHT | WEIGHT |
|---|---|---|---|---|---|---|---|---|---|
| | | | - - | | | | ☐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.**

Was any person listed on this application enrolled in health care coverage (i.e. group health plan, individual coverage, Medicare, Medicaid, etc.) at any time within the last 63 days? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No

If Yes, is the coverage in effect? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No

If you answered "Yes", please complete the following information for each person who was covered at any time within the last 63 days. [Attach additional sheets if necessary] *(continued on page 3)*

## 5. OTHER COVERAGE CONTINUED...

1. Covered Person's Name: ________________________________________________
2. How many months did this person have health care coverage without any break in coverage? ______

Provide the following information for each insurance policy the above-named person was covered under during the past 2 years:

3. Policy Holder's Name: __________________________________ Sex: ☐ M ☐ F Date of Birth ____/____/____
4. Name and Location of Insurance Company: ________________________________________________
5. Policy Number: ______________________ Policy covers: ☐ Policy Holder Only ☐ Two-Party ☐ Family
6. Effective Date of Policy: ____/____/____
7. Cancellation Date of Policy: ____/____/____ Reason for cancellation ______________________________
8. 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 |

9. Was coverage through an employer or other group? ☐ Yes ☐ No
   If "Yes", name of employer or other group: ________________________________________________
10. Was coverage through an individual insurance policy? ☐ Yes ☐ No

## 6. HIPAA ELIGIBILITY INFORMATION

| | YES | NO |
|---|---|---|
| 1. Is the applicant eligible (whether enrolled or not) for coverage under any group health benefits plan or employer sponsored health benefit plan?<br>If yes, please state the name of the applicant ________________________________ | ☐ | ☐ |
| 2. Is the applicant eligible or entitled (whether enrolled or not) for Medicare, Part A or Part B?<br>If entitled, please state the name of the applicant ________________________________<br>and the applicant's Medicare Claim Number ________________________________ | ☐ | ☐ |
| 3. Is the applicant eligible (whether enrolled or not) for Medicaid, or any similar state plan under Title XIX of the Social Security Act?<br>If yes, please state the name of the applicant ________________________________ | ☐ | ☐ |
| 4. Is the applicant currently covered under any other health benefit plan?<br>If yes, please state the name of the applicant ________________________________<br>Provide coverage information in Section 5 (Other Coverage), above. | ☐ | ☐ |

*(continued on page 4)*

## 6. HIPAA ELIGIBILITY INFORMATION CONTINUED...

| | YES | NO |
|---|---|---|
| 5. Was the applicant's prior health benefits plan terminated because of non-payment of premium or subscription charges by the applicant, when due? | ☐ | ☐ |

If yes, please state the name of the applicant ______________________________

| | | |
|---|---|---|
| 6. Was the applicant's prior health benefits plan terminated for reasons of fraudulent act or intentional misrepresentation by the applicant? | ☐ | ☐ |

If yes, please state the name of the applicant ______________________________

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 the applicant was offered this Continuation Coverage, did the applicant refuse this coverage or elect to terminate this coverage before the end of the allowed Continuation Coverage period? | ☐ | ☐ |

If yes, please state the name of the applicant ______________________________

**INSTRUCTIONS:**

**Applicants REQUIRED to Complete the Health Status Section of the Application:**

- Any applicant who has not been covered under any health benefits plan for the past 63 days.
- Any applicant who answered any of the above questions in Section 6 (HIPAA Eligibility Information) with "YES".
- Any applicant who wants to be considered for the Underwritten coverage only or for both the Underwritten coverage (first choice) and the HIPAA coverage (second choice).

**Applicants who are NOT Required to Complete the Health Status Section of the Application:**

- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 18 months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under individual health insurance coverage, a group health plan, governmental plan, or church plan, or any health benefit plan offered in connection with these plans; and 3) the applicant answered all of the above questions in section 6 (HIPAA Eligibility Information) with "NO".
- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 12 months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under an individual health insurance policy which was nonrenewed by the health insurance issuer because the health insurance issuer is no longer offering any type of health insurance coverage in the individual market; and 3) the applicant answered all of the above questions in section 6 (HIPAA Eligibility Information) with "NO".

**NOTE:** An applicant's prior insurer(s) or health plan(s) are 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 and Virginia law. Please attach all Certificates of Coverage to this application. Retain a copy for your records.

## 7. 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 and 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.**

*(continued on page 6)*

## 7. HEALTH EVALUATION 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:<br>TO: | | ☐ FULL<br>☐ PARTIAL |
| | | | FROM:<br>TO: | | ☐ FULL<br>☐ PARTIAL |
| | | | FROM:<br>TO: | | ☐ FULL<br>☐ PARTIAL |
| | | | FROM:<br>TO: | | ☐ FULL<br>☐ 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.**

**The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.**

Signature of Applicant: **X**______________________________ Date:________________

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

Signature of Applicant: **X**______________________________ Date:________________