Individual BluePreferred HSA Application

Maryland Residents

CareFirst BlueCross BlueShield

☐ **CareFirst of Maryland, Inc.**
10455 Mill Run Circle, Owings Mills, MD 21117

☐ **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 if provided, or mail to:
   Mailroom Administrator
   P.O. Box 14651
   Lexington, KY 40512

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.***

If you reside in Prince George's or Montgomery county, please check the Group Hospitalization and Medical Services, Inc. box above. If you live in Baltimore City or any other county in the State of Maryland, please check the CareFirst of Maryland, Inc. box above.

1. APPLICANT INFORMATION (The oldest applicant will be the Subscriber)

Last Name	First Name	Initial	Social Security #

Residence Address: (Number and Street, Apt. #)	City and State	Zip Code (9-digit, if known)

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

Date of Birth / /	Sex ☐ Male ☐ Female	Height	Weight	Requested Effective Date of Coverage / /

Home Phone ( )	Work/Cell Phone ( )	Marital Status ☐ Single ☐ Married ☐ Partner

2. COVERAGE SELECTION: (Check one)

☐ **Individual** – Provides coverage for one person
☐ **Individual & Child(ren)** – Provides coverage for an individual and eligible dependent(s)
☐ **Individual & Adult** – Provides coverage for two eligible adults
☐ **Family** – Provides coverage for two eligible adults and eligible dependent(s)

3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child(ren), Individual & Adult or Family Coverage

	Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	Sex	Height (in.)	Weight (lbs.)
Spouse							☐M ☐F		
Partner							☐M ☐F		
Dependent 1							☐M ☐F		
Dependent 2							☐M ☐F		
Dependent 3							☐M ☐F		
Dependent 4							☐M ☐F		
Dependent 5							☐M ☐F		

4. COVERAGE LEVEL

Check one:	Deductible (In-Network)	Coverage Level (In-Network)	Out-of-Pocket Limit (In-Network)
☐	$1,200 (Individual) / $2,400 (Family)	80%	$2,800 (Individual) / $5,600 (Family)
☐	$2,700 (Individual) / $5,400 (Family)	100%	$3,200 (Individual) / $6,400 (Family)

IMPORTANT DEDUCTIBLE INFORMATION

Individual Coverage: A member must meet their Individual deductible (listed above) before full benefits will begin.

Individual & Child(ren), Individual & Adult, and Family Coverage: The Family deductible (listed above) must be met before full benefits will be available to any member. Once the Family deductible has been met, full benefits will become available to everyone covered.

IMPORTANT OUT-OF-POCKET LIMIT INFORMATION

Individual Coverage: A member must meet their Individual out-of-pocket limit (listed above) before the member will no longer be responsible for deductible, copayments and coinsurance amounts for the benefit period.

Individual & Child(ren), Individual & Adult, and Family Coverage: The Family out-of-pocket limit (listed above) must be met before members in a family category will no longer be responsible for deductible, copayments and coinsurance amounts for the benefit period.

MATERNITY BENEFITS: Check this box if you wish to include benefits for maternity services (additional cost). ..... ☐ Yes

VISION BENEFITS: Check this box if you wish to include benefits for vision services (additional cost)..... ☐ Yes

5. 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 and 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 BlueCross BlueShield 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):_____

6. HEALTH EVALUATION

PLEASE COMPLETE SECTIONS A, B AND C. CHECK EACH ITEM "YES" OR "NO."

NOTE: An individual under age 19 who is included on the enrollment application as a spouse, partner or dependent shall not be denied coverage as a result of medical underwriting.

YES NO

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

SECTION 6A — If any person included in this application is presently using or has used medication or prescription drugs in the past 5 years, please provide the following information.

Name of Family Member	Illness or Condition	Medication	Dosage	Date of Last Treatment	How Often Taken	Attending Physician Name and Address

6. HEALTH EVALUATION

SECTION 6B — To the best of your knowledge and belief, do you know if any person named in this application had within the last five years, or do you know if such person now has, any of the following:

		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	☐	☐
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.	Use of illicit drugs	☐	☐
8.	Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	☐	☐
9.	Cataract or other eye condition	☐	☐
10.	Tuberculosis, lung condition, asthma, bronchitis	☐	☐
11.	Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	☐	☐
12.	Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)	☐	☐
13.	(Female) Irregular or excessive menstrual bleeding, reproductive system disorders, breast condition	☐	☐
14.	(Female) is currently pregnant; expected date of delivery: _____/_____/_____	☐	☐
15.	(Male) Prostate condition, reproductive system disorders	☐	☐
16.	Do you or your spouse or partner have known infertility or any known disorder related to infertility	☐	☐
17.	Have you or your spouse or partner received any treatment or diagnostic “work-up” related to infertility	☐	☐
18.	Have you been told that you have high or elevated cholesterol, lipids or triglycerides	☐	☐
19.	Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	☐	☐
20.	Sexually transmitted diseases	☐	☐
21.	Anemia, blood disorders	☐	☐
22.	Smoked cigarettes or used tobacco products	☐	☐
23.	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 1-22?	☐	☐
24.	Had any known departure from good health not previously mentioned in this questionnaire for which advice, diagnosis, care or treatment was recommended or received?	☐	☐

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” – Or your application will be returned.

SECTION 6C — If you have checked “YES” to any part of SECTION 6B, for each box 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.

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

Patient’s 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
			FROM: TO:		☐FULL ☐PARTIAL
			FROM: TO:		☐FULL ☐PARTIAL
			FROM: TO:		☐FULL ☐PARTIAL
			FROM: TO:		☐FULL ☐PARTIAL
			FROM: TO:		☐FULL ☐PARTIAL

7. PREMIUM PAYMENT

CareFirst BlueCross BlueShield's standard method of payment for members is automated payment via bank withdrawal. Unless the box is checked below, please provide the following information so that we may establish your automated payment.

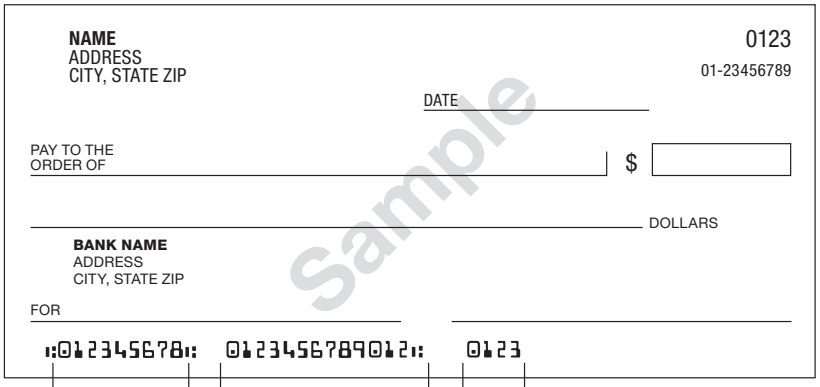
☐ **Checking Account** ☐ **Savings Account**

Bank Name: _____

Routing Number: _____

Account Number: _____

Name that appears on the Account: _____



I hereby authorize Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) or CareFirst of Maryland, Inc., doing business as CareFirst BlueCross BlueShield (CareFirst) to charge my account for the payment of premiums due for an unpaid invoice. If any check draft is dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, CareFirst agrees that the financial institution will not be held liable. I understand that non-payment of premiums due to dishonored auto-draft payment attempts may result in termination of coverage. I also understand that if the Subscriber elects to pay premium through an electronic payment, CareFirst may not debit or charge the amount of the premium due prior to the premium due date, except as authorized by the Subscriber. My recurring payments will be processed on the 6th of each month (including holidays). Members registered for recurring payment will not receive a paper bill in the mail. However, you may view and print your invoice during the recurring payment period from the invoice history online at **www.carefirst.com/myaccount**.

Signature of Account Holder: X _____ Date: _____

☐ **Check this box if you intend to pay by submitting paper checks or by credit card.**

8. ELECTRONIC COMMUNICATION CONSENT

You can receive electronic notices via email instead of paper notices for your CareFirst BlueCross BlueShield (CareFirst) health care coverage by providing your email address and consent below.

These will include but are not limited to

- Explanation of Benefits alerts
- Appeal decision alerts
- Notice of HIPAA Privacy Practices
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

- You may change your email and consent information anytime by logging into **www.carefirst.com/myaccount** or by calling the customer service phone number on your ID card.
- You can request a paper copy of electronic notices at anytime by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

❑ **By checking this box, I hereby agree to electronic delivery of notices and documents instead of paper delivery.**

Applicant Name	Email Address
Spouse / Partner / Eligible Dependent Name(s)	Email Address

CareFirst will not sell your email to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.

9. 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, from Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) or CareFirst of Maryland, Inc., doing business as CareFirst BlueCross Blueshield (CareFirst).

This information is subject to verification. To do so I authorize any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company including MIB, Inc. to release my "Medical Information" to Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) or CareFirst of Maryland, Inc., doing business as CareFirst BlueCross Blueshield (CareFirst) or CareFirst's business associates or representatives. I further authorize any business associate who receives "Medical Information" from any physician, hospital pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company including MIB, Inc. to release my "Medical Information" to CareFirst. I understand that my Medical Information consists of any diagnoses, treatment, prescriptions from a pharmacy, or any other medically related information about me. I authorize CareFirst to use my Medical Information for underwriting and to determine my eligibility for insurance benefits.

This authorization shall include and apply to any and all protected health information related to treatments where I have requested a restriction to a health care provider to release information and/or for any health care item or service for which I have paid the health care provider in full. I understand this authorization will remain in effect for 30 months from the date signed.

I understand that I have the right to cancel this authorization at any time, in writing, except to the extent that CareFirst has already taken action in reliance on this authorization. I also understand that CareFirst's Notice of Privacy Practices includes information pertaining to authorizations and to requirements of revocation. A copy of the Notice may be obtained by contacting the CareFirst's Privacy Office. CareFirst will not use or disclose the Medical Information for any purposes other than those listed above except as may be required by law. CareFirst is required to tell you by law that information disclosed pursuant to this authorization may be subject to re-disclosure and that under some limited circumstances will no longer be protected by federal privacy regulations.

If CareFirst determines that additional information is needed, I will receive an authorization to release that information. Failure to execute an authorization may result in the denial of my application for coverage. Additionally I understand that failure to complete any section of this application, including signing below, may delay the processing of my application.

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 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 or cancellation of my policy. CareFirst may rescind or void my coverage only if (1) I have performed an act, practice, or omission that constitutes fraud; or (2) I have made an intentional misrepresentation of material fact. CareFirst will provide 30-days advance written notice of any rescission of coverage and refund any premiums to the Subscriber. The Member is responsible for repayment of any claim payment made by CareFirst on the Member's behalf.

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

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.

An applicant or dependent age 19 or older whose application is denied by CareFirst BlueCross BlueShield due to medical underwriting may not submit a new application for enrollment within ninety (90) days of the denial.

WARNING: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Information regarding your insurability will be treated as confidential. CareFirst or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Regarding MIB: Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642) If you question the accuracy of the information in the MIB file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. CareFirst or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

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

Signature of Applicant 1:* X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____
(Spouse or Partner)

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

*Rates are based on the age of the Subscriber (oldest applicant).

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian must be signed by the parent or legal guardian.

Parent or Legal Guardian's Signature: X _____ Date: _____

FOR OFFICE USE ONLY:

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

Signature of Applicant 1: X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____
(Spouse or Partner)

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Signature of Eligible Dependent: X _____ Date: _____
Any dependent 18 years of age or older must sign

Parent or Legal Guardian's Signature: X _____ Date: _____

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