CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

# CareFirst BlueChoice, Inc.
# BlueChoice HMO HRA/HSA Enrollment Form

**(Maryland Groups)**

**THIS IS NOT AN APPLICATION FOR INSURANCE**

**HOW TO COMPLETE THIS ENROLLMENT FORM:**

1. Please type or print clearly with ball point pen.
2. Complete all appropriate items, sign and date.
3. **You MUST** include a Primary Care Physician name and code number for each dependent listed. The Physician Code # is located in the Provider Directory. **Failure to provide this information may delay in-network services.**
4. Please return your Form to your Employer.
5. **Employer must complete if Section VI is answered.** Number of employees in group _____.

## I. APPLICANT

Employer/Group Administrator

Group Number _____

Medical Option_____ Dental Option_____

Vision Option_____

Effective Date Requested / /

Social Security Number

Date of Birth / /

Sex ☐ Male ☐ Female

Last Name | First Name | Middle Initial

Date of Hire / /

Occupation

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired

Residence Address *(Number and Street)* *(City and State)* *(Zip Code-9 digit, if known)*

Home Phone ( )

Work Phone ( )

Status ☐ Single ☐ Married/Partner ☐ Other ☐ Legally Separated ☐ Divorced

Name of Primary Care Physician

Physician Code #

Current Patient ☐ Yes ☐ No

## II. TYPE OF ENROLLMENT

**CHECK ONE:**

☐ New ☐ Coverage Change

## III. TYPE OF COVERAGE

**TYPE OF COVERAGE**

☐ HRA Option # _____
☐ HSA Option # _____

Please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section to avoid delays in processing this Enrollment Form.

**CHECK ONE:**

☐ Individual
☐ Individual and Adult
☐ Individual and Child
☐ Individual and Children
☐ Family
☐ Coverage Complementary to Medicare (Individual Only and benefit coverage only; not eligible for HSA Accounts.)

**CHECK ONE:**

☐ Dental HMO
☐ Dental HMO Opt-Out
☐ Preferred Dental
☐ Traditional Dental
☐ BlueVision *Plus*

## IV. CHANGE TO EXISTING COVERAGE

**Dependents affected by adds or deletes must be listed in Section V - Dependent Information**

Identification Number, if different from Social Security Number

_____

☐ *ADD* dependent(s) listed in Section V

☐ *ADD* spouse due to marriage on_____(Date)

☐ *ADD* partner on_____(Date)

☐ *ADD* child due to **adoption** on _____(Date) or appointed **legal guardian** by court decree dated _____.

**(Note: Documentation of adoption or court-appointed legal guardianship must be provided. CareFirst BlueChoice will pay the cost of the documentation required to provide proof of adoption or court-appointed legal guardianship.)**

☐ *REMOVE* dependent(s) listed in Section V due to_____

_____(Reason)_____(Date)

☐ *CHANGE* address to that shown in Section I above

☐ *CHANGE* my name from_____ to that shown in Section I

☐ *CHANGE* Primary Care Physician to that shown in Section I for applicant and Section V for dependent

## V. DEPENDENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| 1 | **Spouse/ Partner** | Name - (Last, First, MI) | Social Security No. | Date of Birth / / | Sex ☐ Male ☐ Female |
| | | Name of Primary Care Physician | | Physician Code # | Current Patient ☐ Yes ☐ No |
| 2 | **Child** | Name - (Last, First, MI) | Social Security No. | Date of Birth / / | Sex ☐ Male ☐ Female |
| | | Name of Primary Care Physician | | Physician Code # | Current Patient ☐ Yes ☐ No |
| 3 | **Child** | Name - (Last, First, MI) | Social Security No. | Date of Birth / / | Sex ☐ Male ☐ Female |
| | | Name of Primary Care Physician | | Physician Code # | Current Patient ☐ Yes ☐ No |
| 4 | **Child** | Name - (Last, First, MI) | Social Security No. | Date of Birth / / | Sex ☐ Male ☐ Female |
| | | Name of Primary Care Physician | | Physician Code # | Current Patient ☐ Yes ☐ No |

**COMPLETE ONLY IF DEPENDENT CHILD IS A STUDENT OR DISABLED**

| | | | | |
|---|---|---|---|---|
| Dependent Name - (Last, First, MI) | Full-Time Student? ☐ Yes ☐ No | **IF YES, ATTACH STUDENT CERTIFICATION FORM** | Disabled? ☐ Yes ☐ No | **IF YES, ATTACH DISABILITY CERTIFICATION FORM AND SUPPORTING DOCUMENTATION** |
| Dependent Name - (Last, First, MI) | Full-Time Student? ☐ Yes ☐ No | | Disabled? ☐ Yes ☐ No | |

## VI. MEDICARE COVERAGE

FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, WILL CAUSE SIGNIFICANT PROCESSING DELAYS.

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

Name_____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No._____Eligible for: ☐ Part A Eff. Date____/____/____ ☐ Part B Eff. Date____/____/____

Name_____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No._____Eligible for: ☐ Part A Eff. Date____/____/____ ☐ Part B Eff. Date____/____/____

EMPLOYEE STATUS: (CHECK ONLY ONE BOX) ☐ Actively Employed ☐ Retired

## VII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION (continued)

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

☐ Check this block if any person listed on this Form 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, another insurance carrier or Medicaid. Is this coverage currently in effect? ☐ Yes ☐ No
If Yes, will this coverage be continued? ☐ Yes ☐ No
If No, please provide cancellation date_____/_____/_____

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-Persons ☐ Family
4. Effective Date of Policy_____/_____/_____
5. Service(s) Covered: month day year

| | | | |
|---|---|---|---|
| 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. Mental Illness Services | ☐ Yes ☐ No |
| D. Separate Drug Program | ☐ Yes ☐ No | H. HMO | ☐ Yes ☐ No |

6. Is coverage through an employer or other group? ☐ Yes ☐ No
   If Yes, name of employer or other group_____
7. Is this coverage under COBRA? ☐ Yes ☐ No Reason for cancellation _____
8. To be completed if the natural parents live apart and provide medical coverage for their children. Please indicate relationship to children (natural mother, natural father, step-parent)

PARENT WITH COURT ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES
_____ ***Parent's Name / Relationship***
_____ ***Child's Name / Date of Birth***

PARENT WITH CUSTODY OF CHILD(REN)
_____ ***Parent's Name / Relationship***
_____ ***Child's Name / Date of Birth***

## VIII. PLEASE READ CAREFULLY - THIS SECTION MUST BE DATED AND SIGNED

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this Form is accepted, coverage will be provided according to the terms and conditions of the contract between CareFirst BlueChoice, Inc. and my employer. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future subscription charges to my employer.

**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.**

**I have carefully read this Form and agree to its terms. The recorded answers on this Form are, to the best of my knowledge and belief, full, complete and true as of this date.**

**This information is subject to verification. Failure to complete any section may delay the processing of your Form 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 enrollment for coverage.**

**If you have any questions concerning the benefits and services that are provided by or excluded under the coverage for which you are applying, please contact a membership services representative before signing this Form.**

**X** _____ **/ /** _____
**Signature of Applicant** **Date**

BlueFund
CONSUMER DIRECTED HEALTH PLANS