CareFirst BlueChoice

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

CareFirst BlueChoice, Inc. Enrollment Form

(Virginia Groups)

HOW TO COMPLETE THIS 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 Employed / /	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
Name of Primary Care Physician	Physician Code #	Current Patient ☐ Yes ☐ No

II. TYPE OF ENROLLMENT

CHECK ONE:

☐ New ☐ Coverage Change

III. TYPE OF COVERAGE

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)

CHECK ONE:

☐ BlueChoice
☐ BlueChoice *Open Access*
☐ BlueChoice Opt-Out *Open Access*

☐ 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.)

☐ *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**	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	**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
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
5	**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 or another insurance carrier. 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.

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.

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.

X _____ _____
Signature of Applicant **Date**