



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

CareFirst BlueChoice, Inc. Enrollment Form (Virginia Groups)

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 _____	
Effective Date Requested / /		Medical Option _____ Dental Option _____	
Social Security Number		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name		First Name	Initial
Date Employed / /	Occupation	Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired	
Residence Address (Number and Street)		(City and State) (Zip Code-9 digit, if known)	
Home Phone ()	Work Phone ()	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
II. TYPE OF ENROLLMENT		IV. CHANGE TO EXISTING COVERAGE	
CHECK ONE: <input type="checkbox"/> New <input type="checkbox"/> Coverage Change		Dependents affected by adds or deletes must be listed in Section V - Dependent Information Identification Number, if different from Social Security Number _____	
III. TYPE OF COVERAGE		<input type="checkbox"/> ADD dependent(s) listed in Section V <input type="checkbox"/> ADD spouse due to marriage on _____ (Date) <input type="checkbox"/> 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.) <input type="checkbox"/> REMOVE dependent(s) listed in Section V due to _____ _____ (Reason) _____ (Date)	
CHECK ONE: <input type="checkbox"/> Self-Only Coverage <input type="checkbox"/> Self and Spouse (Two-Party) <input type="checkbox"/> Self and Child (Two-Party) <input type="checkbox"/> Family <input type="checkbox"/> Coverage Complementary to Medicare (Self-Only)		<input type="checkbox"/> CHANGE address to that shown in Section I above <input type="checkbox"/> CHANGE my name from _____ to that shown in Section I <input type="checkbox"/> CHANGE Primary Care Physician to that shown in Section I for applicant and Section V for dependent	
Coverage Selected: Check only those options that your employer has elected to offer. <input type="checkbox"/> BlueChoice <input type="checkbox"/> BlueChoice Opt-Out <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental HMO Opt-Out <input type="checkbox"/> Preferred Dental <input type="checkbox"/> Traditional Dental <input type="checkbox"/> BlueVision Plus			

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V. DEPENDENT INFORMATION

1 Spouse	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
2 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
3 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
4 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

COMPLETE ONLY IF DEPENDENT CHILD LISTED ABOVE IS AGE 19 OR OVER

Dependent Name - (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH STUDENT CERTIFICATION Form	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH DISABILITY CERTIFICATION Form AND SUPPORTING DOCUMENTATION
Dependent Name - (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> 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

IF YOU HAVE OTHER COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

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 _____ Date of Birth ____/____/____

2. Name and Location of Insurance Company _____

3. Policy Number _____ Effective Date ____/____/____

4. Policy Covers Policy Holder Only Two Persons Family

5. Is coverage through an employer or other group? Yes No

Employer/Group Name _____

6. Services Covered:
- | | | |
|--------------------------------|------------------------------|-----------------------------|
| A. Hospital | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Physician | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Out-of-pocket Major Medical | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Separate Drug Program | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Dental | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Eye or Vision Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Mental Illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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 _____ X _____
Date Signature of Applicant