Group Hospitalization and Medical Services, Inc.
CareFirst BlueChoice, Inc.
1440 G Street, NW
Washington, DC 20005

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc.

Enrollment Form

(Virginia Small Groups)

This form is used for dually offered products with in-network benefits provided by CareFirst BlueChoice, Inc., and out-of-network benefits provided by CareFirst BlueCross BlueShield.

HOW TO COMPLETE THIS FORM:

1. Please type or print clearly with pen.
2. Complete all appropriate items, sign and date.
3. For some plans below, 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 this form to your employer.
5. **Employer must complete if Section VII is answered** – Number of employees in group: _____.

I. EMPLOYER INFORMATION – To be completed by the employer	
Employer / Group Administrator	Group Number _____
Effective Date Requested / /	

II. ENROLLEE			
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 ( )	Marital Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Other ☐ Separated ☐ Divorced	
Primary Care Physician (PCP)		Physician Code Number	Current Patient ☐ Yes ☐ No

III. TYPE OF ENROLLMENT
CHECK ONE: ☐ New ☐ Coverage Change

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IV. PLAN SELECTION

To avoid delays in processing this form, please confirm with your employer the details of the benefit options offered by your employer prior to completing this section. CHECK ONLY ONE:

PCP selection is not required for the following plans:

- ☐ BlueChoice Advantage Platinum 0 Med Ded 25 Dent Ded
- ☐ BlueChoice Advantage Platinum 500 Med Ded 25 Dent Ded
- ☐ BlueChoice Advantage Gold 0 Med Ded 25 Dent Ded
- ☐ BlueChoice Advantage Gold 800 Med Ded 250 Drug Ded 25 Dent Ded
- ☐ BlueChoice Advantage Gold 1000 Med Ded 250 Drug Ded 25 Dent Ded
- ☐ BlueChoice Advantage HSA/HRA Gold 1800 Med Ded 25 Dent Ded
- ☐ BlueChoice Advantage Gold 3000 Med Ded 250 Drug Ded 25 Dent Ded
- ☐ BlueChoice Advantage HSA/HRA Silver 2300 Med Ded 25 Dent Ded
- ☐ BlueChoice Advantage HSA/HRA Silver 2650 Med Ded 25 Dent Ded
- ☐ BlueChoice Advantage HSA/HRA Silver 3400 Med Ded 25 Dent Ded
- ☐ BlueChoice Advantage Silver 5350 Med Ded 450 Drug Ded 25 Dent Ded
- ☐ BlueChoice Advantage Silver 6900 Med Ded 450 Drug Ded 25 Dent Ded
- ☐ BlueChoice Advantage Bronze 6000 Med Ded 25 Dent Ded
- ☐ BlueChoice Advantage HSA/HRA Bronze 6100 Med Ded 25 Dent Ded

PCP selection is required for the following plans:

- ☐ BlueChoice Plus Platinum 500 Med Ded 25 Dent Ded
- ☐ BlueChoice Plus Gold 800 Med Ded 250 Drug Ded 25 Dent Ded
- ☐ BlueChoice Plus Gold 1000 Med Ded 250 Drug Ded 25 Dent Ded
- ☐ BlueChoice Plus HSA/HRA Silver 2300 Med Ded 25 Dent Ded
- ☐ BlueChoice Plus HSA/HRA Silver 3050 Med Ded 25 Dent Ded
- ☐ BlueChoice Plus HSA/HRA Silver 3400 Med Ded 25 Dent Ded
- ☐ BlueChoice Plus HSA/HRA Bronze 6100 Med Ded 25 Dent Ded

V. CHANGE TO EXISTING ENROLLMENT

Dependents affected by additions or deletions must be listed in Section VI - Dependent Information.

Identification Number, if different from Social Security Number: _____

- ☐ ADD dependent(s) listed in Section VI
- ☐ ADD spouse due to marriage on _____ (Date)
- ☐ ADD domestic 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 VI due to _____ _____ (Reason) on _____(Date)
- ☐ CHANGE address to that shown in Section II
- ☐ CHANGE my name from _____ _____ to that shown in Section II
- ☐ CHANGE Primary Care Physician to that shown in Section II for enrollee or Section VI for dependent(s)

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VI. DEPENDENT INFORMATION

1	Spouse	Name – (Last, First, MI)	Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	
		Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No
2	Domestic Partner	Name – (Last, First, MI)	Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	
		Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No
3	Child	Name – (Last, First, MI)	Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	
		Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No
4	Child	Name – (Last, First, MI)	Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	
		Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No
5	Child	Name – (Last, First, MI)	Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	
		Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No
6	Child	Name – (Last, First, MI)	Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	
		Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No

COMPLETE ONLY IF DEPENDENT CHILD IS A STUDENT OR DISABLED (AGE 26 OR OLDER)

If dependent child is a student age 26 or older, please confirm coverage with your employer prior to completing this section.

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	

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VII. MEDICARE COVERAGE

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

☐ Check this box if any person listed on this form is eligible for or receiving benefits under Medicare.
If you checked the box, 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 ___ /____ /____

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

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

Medicare Claim No. _____ Eligible for: ☐ Part A Eff. Date ____ /____ /____ ☐ Part B Eff. Date ___ /____ /____

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

VIII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION

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

☐ Check this box 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 and Social Security Number _____
   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 _____ /_____ /_____
   month day year
5. Service(s) Covered:
   A. Hospital Services ☐ Yes ☐ No
   B. Physician Services ☐ Yes ☐ No
   C. Major Medical (out-of-pocket expenses) ☐ Yes ☐ No
   D. Separate Drug Program ☐ Yes ☐ No
   E. Dental ☐ Yes ☐ No
   F. Eye/Vision Care Services ☐ Yes ☐ No
   G. Mental Illness Services ☐ 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
8. To be completed if the parents live apart and provide medical coverage for their child(ren):
   Please indicate relationship to child(ren).

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

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IX. PLEASE READ CAREFULLY – THIS SECTION MUST BE DATED AND SIGNED

I hereby enroll, on behalf of myself and each dependent listed above, for the coverage indicated. I understand that this is a dually offered product with in-network benefits provided by CareFirst BlueChoice, Inc., and out-of-network benefits provided by CareFirst BlueCross BlueShield. Coverage will be provided according to the terms and conditions of the contract between CareFirst BlueChoice, Inc., CareFirst BlueCross BlueShield, 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 charges to my employer.

CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield 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 BlueChoice, Inc. and CareFirst BlueCross BlueShield will provide 30-days advance written notice of any rescission of coverage and refund any paid premiums to the group.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia state law.

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.

_____

Enrollee Signature Date

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X. CONSENT TO RECEIVE ELECTRONIC NOTICES

CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield want to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield health care coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield health care coverage include, but are not limited to:

- Explanation of Benefits alerts
- Reminders
- 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.

Please note, you may change your email, cell phone 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 also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically through email, 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).

I understand that to receive notices through text messaging:

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery, by:

☐ Email only
☐ Cell phone text messaging only
☐ Email and cell phone text messaging

By signing below, I hereby agree to electronic delivery of notices.

Member Name	Signature and Date	Email Address	Cell Phone Number

By signing below, my dependents (spouse or domestic partner, and any other dependents) covered by CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield individually agree to electronic delivery of notices.

Dependent Name	Signature and Date	Email Address	Cell Phone Number

CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield will not sell your email address or cell phone number to any third party and we do not share them with third parties except for CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield vendors that perform functions on our behalf or to comply with the law.

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XI. RACE, ETHNICITY, LANGUAGE (This information is voluntary.)

CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield are asking their members to voluntarily provide their race, ethnicity, and language attributes. The information provided, while voluntary, will assist us to improve quality of care and access to care, thereby reducing health care disparities and promoting better health outcomes. The information you provide will not have a negative impact on any services we provide to you. The information is kept strictly confidential and will not be shared unless we are required by law to disclose it.

Race
White/Caucasian
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Other – (To include Multi-Racial)
Decline to answer
Unknown – Could not be determined

Ethnicity
Hispanic/Latino/Spanish origin

Preferred Spoken Language*
01 English
02 Albanian
03 Amharic
04 Arabic
05 Burmese
06 Cantonese
07 Chinese (simplified & traditional)
08 Creole (Haitian)
09 Farsi
10 French (European)
11 Greek
12 Gujarati
13 Hindi
14 Italian
15 Korean
16 Mandarin
17 Portuguese (Brazilian)
18 Russian
19 Serbian
20 Somali
21 Spanish (Latin America)
22 Tagalog (Filipino)
23 Urdu
24 Vietnamese
98 Other and unspecified languages
99 Unknown

Last Name		First Name	Race	Ethnicity	Country of Origin	Preferred Spoken Language (*specify number from above)
Enrollee						
Spouse						
Domestic Partner						
Child						
Child						
Child						
Child						

Enrollee Signature Date

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