CareFirst of Maryland, Inc.
6100 Merriweather Drive,
Suite 300, Columbia, MD
21044

Enrollment Form

(Maryland Groups not located in Montgomery and Prince George's Counties)
THIS IS NOT AN APPLICATION FOR INSURANCE

HOW TO COMPLETE THIS FORM:

1. Please type or print clearly with pen.
2. Complete all appropriate items, sign and date.
3. Please return this form to your employer.
4. **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	Effective Date Requested / /	Group Number

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

III. TYPE OF ENROLLMENT

CHECK ONE: ☐ New ☐ Coverage Change

IV. TYPE OF COVERAGE

To avoid delays in processing this form, please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section.

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)

IF ENROLLING FOR MEDICAL COVERAGE, CHECK ONE:
- ☐ [BluePreferred, Option _____]
- ☐ [BlueFund BluePreferred HRA, Option _____]
- ☐ [BlueFund BluePreferred HSA, Option _____]
- ☐ [BluePreferred HRA Compatible, Option ___]
- ☐ [BluePreferred HSA Compatible, Option ___]
- ☐ [Other_____]

CHECK ALL APPLICABLE:
- ☐ [Preferred Dental]
- ☐ [Traditional Dental]
- ☐ [BlueDental *Plus*]
- ☐ [BlueDental *EPO*]
- ☐ [BlueDental *Basic*]
- ☐ [BlueVision *Plus*]
- ☐ [Other_____]

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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

VI. DEPENDENT INFORMATION

1	**Spouse / Domestic Partner**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /		Sex ☐ Male ☐ Female
2	**Child**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /		Sex ☐ Male ☐ Female
3	**Child**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /		Sex ☐ Male ☐ Female
4	**Child**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /		Sex ☐ Male ☐ Female
5	**Child**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /		Sex ☐ Male ☐ Female

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	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
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

_____
Child's Name / Date of Birth

PARENT WITH CUSTODY OF CHILD(REN)

_____
Parent's Name / Relationship

_____
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. Coverage will be provided according to the terms and conditions of the contract between CareFirst BlueCross BlueShield and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution.

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 BlueCross BlueShield will provide 30-days advance written notice of any rescission of coverage.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 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.

Enrollee Signature Date

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X. CONSENT TO RECEIVE ELECTRONIC NOTICES

CareFirst BlueCross BlueShield wants 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 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 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	Email Address	Cell Phone Number

By signing below, my spouse/partner and any other dependents covered by my employer individually agree to electronic delivery of notices.

Spouse/Partner/ Dependent Name	Signature	Email Address	Cell Phone Number

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 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 is asking 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 promote better health outcomes. The information you provide will not have a negative impact on any services we provide you. The information is kept strictly confidential and will not be shared unless required by law.

Race
White/Caucasian
Black or African American
American Indian/Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Other – (To include Multi-Racial)
Declined 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 (Pilipino)
23 Urdu
24 Vietnamese
98 Other and unspecified languages
99 Unknown

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

Enrollee Signature Date

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