CareFirst BlueChoice, Inc.
1440 G Street, NW
Washington, DC 20005

CareFirst BlueChoice, Inc.
Enrollment Form

(Maryland Small Groups)

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. 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	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

Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No

Tobacco Usage (*Tobacco usage means use of tobacco, including cigarettes, on average four or more times per week within no longer than the past 6 months)*
☐ Yes ☐ No

III. TYPE OF ENROLLMENT

CHECK ONE: ☐ New ☐ New due to confirmation of pregnancy by a healthcare provider on _____ (Date) (must be within the last 90 days) ☐ Coverage Change

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:

- ☐ BlueChoice HMO HSA/HRA Silver 2800 Ded
- ☐ BlueChoice HMO HSA/HRA Silver 3050 Ded
- ☐ BlueChoice HMO HSA/HRA Silver 3150 Ded
- ☐ BlueChoice HMO HSA/HRA Silver 3400 Ded
- ☐ BlueChoice HMO Silver 2200 Ded
- ☐ BlueChoice HMO Silver 6900 Ded
- ☐ BlueChoice HMO HSA/HRA Gold 1900 Ded
- ☐ BlueChoice HMO Gold 3000 Ded
- ☐ BlueChoice HMO Gold 800 Ded
- ☐ BlueChoice HMO Gold 1500 Ded
- ☐ BlueChoice HMO Platinum 0 Ded
- ☐ BlueChoice HMO HSA/HRA Bronze 6100 Ded
- ☐ BlueChoice HMO Bronze 6000 Ded
- ☐ BlueChoice HMO Referral Silver 5500 Ded
- ☐ BlueChoice HMO Referral Gold 0 Ded
- ☐ BlueChoice HMO Referral Gold 800 Ded
- ☐ BlueChoice HMO Referral Platinum 0 Ded
- ☐ BlueChoice HMO Referral HSA/HRA Bronze 6200 Ded
- ☐ BlueChoice HMO Referral Bronze 9700 Ded

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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 dependent(s) due to confirmation of pregnancy by a health care provider 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)

VI. DEPENDENT INFORMATION

1	**Spouse**	Name – (Last, First, MI)		Social Security Number	
		Date of Birth / /		Sex ☐ Male ☐ Female	
		Tobacco Usage* ☐ Yes ☐ No	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	
		Tobacco Usage* ☐ Yes ☐ No	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	
		Tobacco Usage* ☐ Yes ☐ No	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	
		Tobacco Usage* ☐ Yes ☐ No	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	
		Tobacco Usage* ☐ Yes ☐ No	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	
		Tobacco Usage* ☐ Yes ☐ No	Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No

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

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

Child's 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**
Child's 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 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 charges to my employer.

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

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 we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in a delay in the effective date of 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.

_____ _____

Enrollee Signature Date

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X. CONSENT TO RECEIVE ELECTRONIC NOTICES

CareFirst BlueChoice, Inc. 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 CareFirst BlueChoice, Inc. 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. 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 CareFirst BlueChoice, Inc. individually agree to electronic delivery of notices.

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

CareFirst BlueChoice, Inc. 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. 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.)

As required by Maryland law, CareFirst BlueChoice, Inc. is asking its members to voluntarily provide their race, ethnicity, and language attributes. The information provided, while voluntary, will assist the State of Maryland and CareFirst BlueChoice, Inc. 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 to 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 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 1						
Child 2						
Child 3						
Child 4						
Child 5						
Child 6						

Enrollee Signature Date

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