BlueDental Preferred Application

Virginia Residents

Group Hospitalization and Medical Services, Inc.
1440 G Street, NW, Washington, D.C. 20005
A private not-for-profit health service plan.

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Sign and return this application in the postage-paid return envelope, if provided, or mail to:
   Mail Administrator
   P.O. Box 14651, Lexington, KY 40512

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If incomplete, the application will be returned and your coverage will be delayed.***

Please check if you are applying for new coverage or making changes to a current policy.

◯ New coverage ◯ Making changes

Is this plan intended to replace any other insurance presently in force? ◯ **Yes** ◯ **No**

If Yes, please contact CareFirst to obtain, sign and return the required NOTICE TO APPLICANT REGARDING REPLACEMENT OF AN INSURANCE POLICY.

Note that an insurer may not replace any policy that qualifies as minimum essential coverage with an excepted benefits policy unless specifically requested in writing by the insured. If the sale of the policy will involve a replacement, an insurer shall furnish to the applicant, prior to issuance or delivery of the policy, the notice required in subsection D of the Virginia Administrative Code 14VAC5-141-150. A copy of the notice signed by the applicant shall be retained by the insurer.

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

Residence Address (Number and Street, Apt #)	City	State	Zip Code (9-digit, if known)

Billing Address, if different (Number and Street, Apt #)	City	State	Zip Code (9-digit, if known)

Payment Option	Date of Birth	Sex	Marital Status
◯ Annually ◯ Quarterly	/ /	◯ Male ◯ Female	◯ Single ◯ Married ◯ Domestic Partner

Home Phone	Work/Mobile Phone
( )	( )

2. DEDUCTIBLE SELECTION *(check one)*

◯ **Low Option** ($100 individual in-network deductible)	◯ **High Option** ($50 individual in-network deductible)

This is an excepted benefits policy. It provides coverage only for the limited benefits or services specified in the policy.

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc., an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

3. ENROLLING FAMILY MEMBER(S)—Only list family members to be covered on this plan

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							◯ M ◯ F
Domestic Partner							◯ M ◯ F
Dependent 1							◯ M ◯ F
Dependent 2							◯ M ◯ F
Dependent 3							◯ M ◯ F
Dependent 4							◯ M ◯ F
Dependent 5							◯ M ◯ F

4. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield (CareFirst) 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 health care coverage through email and/or text messaging by providing your email address and/or mobile phone number and consent below.

Electronic notices regarding your CareFirst 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 current plan(s) and services along with new plans and services that may interest you.

Please note: This consent for electronic communications applies to the primary applicant only. A spouse or domestic partner and/or dependents 18 years of age and older can consent to electronic communications at **carefirst.com/myaccount**. You can also change email and consent information anytime by logging into **carefirst.com/myaccount** or by calling the customer service phone number on your member ID card. You can also request a paper copy of electronic notices by calling the customer service phone number on your member ID card.

I understand that to access the information sent by email, I must have all three of the following:

- Internet access
- An email account that allows me to send and receive emails
- 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 by text message:

- A text messaging plan with my mobile phone provider is required
- Standard text messaging rates will apply

Primary Applicant Name	Email Address	Mobile Phone Number
	Alternate Email Address	Alternate Mobile Phone Number

By checking my preference below, I hereby agree to electronic delivery of notices instead of paper delivery.

◯ Email only ◯ Mobile phone text messaging only ◯ Email and mobile phone text messaging

Signature:

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst Business Associates that perform functions on CareFirst's behalf or to comply with the law.

5. CONDITIONS OF ENROLLMENT *(please read this section carefully)*

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the applicant (or to a person authorized to act on his/her behalf).

This information is subject to verification. Failure to complete any section may delay the processing of your application 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 the denial of your application for coverage.

Premium payment options are available on an annual and a quarterly basis.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for, a CareFirst policy.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative toll-free at (866) 891-2802 before signing this application.

WARNING: 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.

The undersigned applicant and agent (if applicable) certify that the applicant has read, or had read to him/her, the completed application, and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

A coordination of benefits may apply as the result of the existence of other similar insurance providing coverage for the same dental services.

Signature of Primary Applicant	Date
NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.	
Parent or Legal Guardian's Signature	Date
Signature of Agent (if applicable):	Date

FOR OFFICE USE ONLY:

◯ Re-sign and re-date below only if checked.

Signature of Primary Applicant	Date
Signature of Applicant 2 (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature	Date

For Broker Use Only:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
General Agency		[redacted]		
Writing Agent				[redacted]