CareFirst BlueChoice

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

CareFirst BlueCross BlueShield

THIS IS NOT AN APPLICATION FOR INSURANCE

ENROLLMENT FORM

1 EMPLOYER INFORMATION – To be completed by the employer.

Employer/Group Administrator
Mayor & City Council of Ocean City

Effective Date Requested ___ ___ / ___ ___ / ___ ___

	BluePreferred PPO		BlueChoice HMO		High-Deductible PPO and HSA	
	Group #	Pkg	Group #	Pkg	Group #	Pkg/Coverage
☐ Active – Full-time MD-10	1901331	006	1902227	240	1903984	Individual = 006 All others = 016
☐ Retired under 65 non Medicare MD-20	1901333	006	1902228	240	1903986	
☐ Retired over 65 Vision Plan 1903987						
☐ COBRA MD-40	1901332	006	1902229	240	1903985	

2 TYPE OF REQUEST – Check all that apply.

☐ New Subscriber ☐ Add Dependents ☐ Delete Dependents ☐ Waiver
☐ Any information change (name or address change) ☐ Change Benefit Plan

☐ Are you enrolling eligible dependents?
☐ Yes ☐ No

3 CHOOSE YOUR BENEFIT PLAN – Check one.

☐ BluePreferred (PPO)
☐ High-Deductible BluePreferred (PPO)
☐ BlueChoice HMO *Open Access*

For HMO only: As you complete the subscriber/dependent information below, you MUST include a Primary Care Physician name and code number for each dependent listed.

4 SUBSCRIBER INFORMATION

Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___
Subscriber Last Name
First
Middle Initial

Date of Birth __ __ /__ __ /__ __
Sex ☐ Male ☐ Female
Date of Hire __ __ /__ __ /__ __
Status ☐ Single ☐ Married ☐ Other ☐ Divorced
Effective Date of Status ___ ___ / ___ ___ / ___ ___

Residence Address (Number and Street)
City and State
Zip Code

Name of Primary Care Physician
Physician Code #
Current Patient? ☐ Yes ☐ No

5 COVERAGE LEVEL

☐ Employee ☐ Family ☐ Employee +1
☐ Coverage Complementary to Medicare (Individual PPO only)

Home Phone (__ __ __) __ __ __ – __ __ __ __
Work Phone (__ __ __) __ __ __ – __ __ __ __

6 CHANGE TO EXISTING COVERAGE – Check all that apply.

Dependents affected by adds or deletes must be listed in Section 7 Dependent Information.
Identification Number, if different from Social Security Number: _____

☐ *ADD* dependent(s) listed in Section 7
☐ *ADD* spouse due to marriage 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. CareFirst BlueCross BlueShield will pay the cost of the documentation required to provide proof of adoption or court-appointed legal guardianship.)

☐ *REMOVE* dependent(s) listed in Section 7 due to _____ _____ (Reason) __ __ /__ __ /__ __ (Date)
☐ *CHANGE* address to that shown in Section 4 above
☐ *CHANGE* my name from _____ to that shown in Section 4
☐ *CHANGE* Primary Care Physician (HMO Only) to that shown in Section 4 for applicant and Section 7 for dependent.

7 DEPENDENT INFORMATION

If the subscriber has more than four dependents, please list the additional dependents on a separate enrollment form.

Last Name	First	MI	Medical, Drug, BlueVision Plus	Relationship	Sex	Date of Birth	Social Security
Name of Primary Care Physician (HMO Only)			Physician Code #			Current Patient? ☐ Yes ☐ No	
Last Name	First	MI	Medical, Drug, BlueVision Plus	Relationship	Sex	Date of Birth	Social Security
Name of Primary Care Physician (HMO Only)			Physician Code #			Current Patient? ☐ Yes ☐ No	
Last Name	First	MI	Medical, Drug, BlueVision Plus	Relationship	Sex	Date of Birth	Social Security
Name of Primary Care Physician (HMO Only)			Physician Code #			Current Patient? ☐ Yes ☐ No	
Last Name	First	MI	Medical, Drug, BlueVision Plus	Relationship	Sex	Date of Birth	Social Security
Name of Primary Care Physician (HMO Only)			Physician Code #			Current Patient? ☐ Yes ☐ No	

Are any children listed above over the age of 26 and disabled? ☐ Yes ☐ No

If YES, please list the name of the person and attach the disability certification form and supporting documentation. NAME:____________________________

8 MEDICARE INFORMATION – To be completed if applicable.

Are you eligible for Medicare? ☐ Yes ☐ No	If YES, Medicare Number ___ ___ ___–___ ___–___ ___ ___ ___–___ ___	Hosp. Eff. Date (Part A) ___ ___/___ ___/___ ___	Hosp. Eff. Date (Part B) ___ ___/___ ___/___ ___
Reason for Entitlement: ☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled________________________________	
Spouse? ☐ Yes ☐ No	If YES, Medicare Number ___ ___ ___–___ ___–___ ___ ___ ___–___ ___	Hosp. Eff. Date (Part A) ___ ___/___ ___/___ ___	Hosp. Eff. Date (Part B) ___ ___/___ ___/___ ___
Reason for Entitlement: ☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled________________________________	
Child/Dependent? ☐ Yes ☐ No	If YES, Medicare Number ___ ___ ___–___ ___–___ ___ ___ ___–___ ___	Hosp. Eff. Date (Part A) ___ ___/___ ___/___ ___	Hosp. Eff. Date (Part B) ___ ___/___ ___/___ ___
Reason for Entitlement: ☐ Age 65 or older	☐ End Stage Renal Disease	☐ Disabled________________________________	

9 OTHER HEALTH INSURANCE INFORMATION

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

☐ 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	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 ___ ___/___ ___/___ ___

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
Reason for cancellation:

8. To be completed if the natural parents live apart and provide medical coverage for their children.
Please indicate relationship to children (natural mother, natural father, step-parent)

Parent with court assigned responsibility for child(ren)'s medical expenses	**Parent with custody of child(ren)**
Parent's Name / Relationship	Parent's Name / Relationship
Child's Name / Date of Birth	Child's Name / Date of Birth

10 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.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 the denial of your enrollment for coverage.

NOTE: 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.

Signature of Applicant	Date
X	