



CareFirst BlueChoice, Inc.

840 First Street, NE
Washington, DC 20065

CareFirst BlueChoice, Inc.
Enrollment Form
(Virginia Small Groups)

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.
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

III. TYPE OF ENROLLMENT

CHECK ONE: New 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 2900 Med Ded 25 Dent Ded
BlueChoice HMO HSA/HRA Silver 2900 Med Ded 25 Dent Ded SE
BlueChoice HMO Gold 800 Med Ded 250 Drug Ded 25 Dent Ded
BlueChoice HMO Gold 1000 Med Ded 25 Dent Ded SE
BlueChoice HMO Gold 1500 Med Ded 250 Drug Ded 25 Dent Ded
BlueChoice HMO Gold 3000 Med Ded 250 Drug Ded 25 Dent Ded Virtual Connect
BlueChoice HMO Referral Gold 0 Med Ded 25 Dent Ded
BlueChoice HMO Referral Gold 800 Med Ded 250 Drug Ded 25 Dent Ded
BlueChoice HMO Platinum 0 Med Ded 25 Dent Ded
BlueChoice HMO Referral Platinum 0 Med Ded 25 Dent Ded
BlueChoice HMO Referral Silver 5350 Med Ded 450 Drug Ded 25 Dent Ded Virtual Connect
BlueChoice HMO Bronze 6000 Med Ded 25 Dent Ded
BlueChoice HMO HSA/HRA Gold 1600 Med Ded 25 Dent Ded
BlueChoice HMO Silver 1900 Med Ded 250 Drug Ded 25 Dent Ded

- BlueChoice HMO Silver 6500 Med Ded 450 Drug Ded 25 Dent Ded
- BlueChoice HMO HSA/HRA Silver 1800 Med Ded 25 Dent Ded
- BlueChoice HMO HSA/HRA Silver 2250 Med Ded 25 Dent Ded
- BlueChoice HMO HSA/HRA Silver 3200 Med Ded 25 Dent Ded
- BlueChoice HMO HSA/HRA Bronze 6100 Med Ded 25 Dent Ded
- BlueChoice HMO Referral Bronze 8500 Med Ded 25 Dent Ded
- BlueChoice Plus Opt-Out Platinum 0 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: \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> ADD dependent(s) listed in Section VI<br><input type="checkbox"/> ADD spouse due to marriage on _____ (Date)<br><input type="checkbox"/> ADD domestic partner on _____ (Date)<br><input type="checkbox"/> ADD child due to adoption on _____ (Date)<br>or appointed legal guardian by court decree dated _____<br><b>(Note: Documentation of adoption or court-appointed legal guardianship must be provided)</b> | <input type="checkbox"/> REMOVE dependent(s) listed in Section VI due to _____ (Reason)<br>on _____ (Date)<br><input type="checkbox"/> CHANGE address to that shown in Section II<br><input type="checkbox"/> CHANGE my name from _____ to that shown in Section II<br><input type="checkbox"/> CHANGE Primary Care Physician to that shown in Section II for enrollee or Section VI for dependent(s) |
|--|---|

**VI. DEPENDENT INFORMATION**

<b>1</b>	<b>Spouse</b>	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Care Physician
		Physician Code Number		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2</b>	<b>Domestic Partner</b>	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Care Physician
		Physician Code Number		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3</b>	<b>Child</b>	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Care Physician
		Physician Code Number		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4</b>	<b>Child</b>	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Care Physician
		Physician Code Number		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5</b>	<b>Child</b>	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Care Physician
		Physician Code Number		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

**VI. DEPENDENT INFORMATION cont'd**

<b>6</b>	<b>Child</b>	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Care Physician
		Physician Code Number		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, Attach Student Certification Form</b>	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, Attach Disability Certification Form and Supporting Documentation</b>
Child's Name – (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**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                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | E. Dental                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. Physician Services                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | F. Eye / Vision Care Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Major Medical (out-of-pocket expenses) | <input type="checkbox"/> Yes <input type="checkbox"/> No | G. Mental Illness Services    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. Separate Drug Program                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | H. HMO                        | <input type="checkbox"/> Yes <input type="checkbox"/> 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	<i>Parent's Name / Relationship</i>	PARENT WITH CUSTODY OF CHILD(REN)	<i>Parent's Name / Relationship</i>
	<i>Child's Name / Date of Birth</i>		<i>Child's Name / Date of Birth</i>

**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, 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

## 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](http://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. individually agree to electronic delivery of notices.

Dependent Name	Signature and Date	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.

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

CareFirst BlueChoice, Inc. is asking its 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.

- |   |                                |                                       |                           |                                    |
|---|--------------------------------|---------------------------------------|---------------------------|------------------------------------|
| <b>Race</b>                               | <b>Ethnicity</b>               | <b>Preferred Spoken Language*</b>     | 09 Farsi                  | 18 Russian                         |
| White/Caucasian                           | Hispanic/Latino/Spanish origin | 01 English                            | 10 French (European)      | 19 Serbian                         |
| Black or African American                 |                                | 02 Albanian                           | 11 Greek                  | 20 Somali                          |
| American Indian or Alaska Native          |                                | 03 Amharic                            | 12 Gujarati               | 21 Spanish (Latin America)         |
| Asian                                     |                                | 04 Arabic                             | 13 Hindi                  | 22 Tagalog (Filipino)              |
| Native Hawaiian or Other Pacific Islander |                                | 05 Burmese                            | 14 Italian                | 23 Urdu                            |
| Other – (To include Multi-Racial)         |                                | 06 Cantonese                          | 15 Korean                 | 24 Vietnamese                      |
| Decline to answer                         |                                | 07 Chinese (simplified & traditional) | 16 Mandarin               | 98 Other and unspecified languages |
| Unknown – Could not be determined         |                                | 08 Creole (Haitian)                   | 17 Portuguese (Brazilian) | 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 \_\_\_\_\_