

Group Hospitalization and

Medical Services, Inc. 840 First Street, NE

Washington, DC 20065

and date.

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc.

Enrollment Form (Virginia Small Groups)

HOW TO COMPLETE THIS FORM:

- Please type or print clearly with pen.
 Complete all appropriate items, sign
- 3. Please return this form to your employer.
- 4. Employer must complete if Section VII is answered – Number of employees in group:

I. EMPLOYER INFORMA	ATION – To b	e completed by	y the em	ployer				
Employer / Group Administrator			Effective Date Requested		d	Group Number		
II. ENROLLEE								
Social Security Number				Date of Birth / /			Sex Male Female	
Last Name				First Name			Middle Initial	
Date of Hire O	ccupation						ment Status Time Part-Time Retired	
Residence Address (Nun	nber and Stre	et)		(City and State	e)		(Zip Code – 9-digit, if known)	
Home Phone Work Phone ()				Marital Status				
III. TYPE OF ENROLLMI	ENT							
CHECK ONE: New	Coverage C	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:								
BluePreferred PPO Platinum Zero Med Ded 25 Dent Ded SE								
BluePreferred PPO PI)ed							
BluePreferred PPO Platinum 500 Med Ded 25 Dent Ded								
BluePreferred PPO G	old 800 Med	Ded 250 Drug D	ed 25 De	ent Ded				
BluePreferred PPO Gold 1000 Med Ded 250 Drug Ded 25 Dent Ded								
BluePreferred PPO Gold 1250 Med Ded 25 Dent Ded SE								
BluePreferred PPO Gold 1500 Med Ded 250 Drug Ded 25 Dent Ded								
BluePreferred PPO Silver 1900 Med Ded 250 Drug Ded 25 Dent Ded								
BluePreferred PPO HSA/HRA Silver 1950 Med Ded 25 Dent Ded								
BluePreferred PPO H	t Ded							
BluePreferred PPO HSA/HRA Silver 2900 Med Ded 25 Dent Ded SE								

ADD domestic partner on	V.	V. CHANGE TO EXISTING ENROLLMENT							
□ ADD dependent(s) listed in Section VI □ REMOVE dependent(s) listed in Section VI due to mariage on(Date) □ ADD brild due to adoption on(Date) or appointed legal guardian by court decree dated □ CHANGE my name from(Date) □ ADD domestic partner on(Date) or appointed legal guardian by court decree dated □ CHANGE my name from(Date) ■ ADD domestic partner on(Date) or appointed legal guardian by court decree dated □ CHANGE my name from(to that sl in Section II ■ ADD domestic partner on(Date) Name - (Last, First, MI) Social Security Number 1 Spouse Name - (Last, First, MI) Social Security Number 2 Domestic Partner Name - (Last, First, MI) Social Security Number 3 Child Date of Birth Sex 1 Jate of Birth Sex Male	Dependents affected by additions or deletions must be listed in Section VI - Dependent Information.								
□ ADD spouse due to marriage on(Date) □	ld	entification N	Number, if different from Social Security Number	:					
□ ADD child due to adoption on (Date) or appointed legal guardian by court decree dated □ CHANGE address to that shown in Section II □ ADD child due to adoption or court-appointed legal guardianship must be provided) □ Section II □ to that si □ DEFENDENT INFORMATION □ Social Security Number □ to that si 1 Spouse Name - (Last, First, MI) Social Security Number 2 Domestic Partner □ Ame - (Last, First, MI) Social Security Number 2 Domestic Partner □ Ame - (Last, First, MI) Social Security Number 3 Child □ Ame - (Last, First, MI) Social Security Number 3 Child □ Ame - (Last, First, MI) Social Security Number 4 Child □ Ame - (Last, First, MI) Social Security Number 5 Child □ Ame - (Last, First, MI) Social Security Number 6 Child □ Ame - (Last, First, MI) Social Security Number 5 Child □ Ame - (Last, First, MI) Social Security Number 6 Child □ Ame - (Last, First, MI) Social Security Number 6 Child □ Ame - (Last, First, MI) Social Security Number 1 <th></th> <th>ADD depe</th> <th>ndent(s) listed in Section VI</th> <th></th> <th colspan="5">······································</th>		ADD depe	ndent(s) listed in Section VI		······································				
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□ Yes Form □ Support	C	nild Name	(Last First MI)	Full-Time Student?					
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CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc., and is an independent licensee of the Blue Cross and Blue Shield Association. © Registered trademark of the Blue Cross and Blue Shield Association. ©' Registered trademark of CareFirst of Maryland, Inc.

VII. MEDICARE COVERAGE							
FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, W	/ILL 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 er	ntitlement: 🗌 Age 65 or older 🗌 Kidney disease 🗌 Disabled						
Medicare Claim No Eligible for: 🗌 P	'art A Eff. Date / / Part B Eff. Date / /						
EMPLOYMENT STATUS (CHECK ONLY ONE BOX): 🗌 Actively Employed 🔲 Retired							
Name Reason for er	ntitlement: 🔲 Age 65 or older 🔲 Kidney disease 🔲 Disabled						
Medicare Claim No Eligible for: D	art A Eff. Date / / Part B Eff. Date / /						
EMPLOYMENT STATUS (CHECK ONLY ONE BOX):	ly Employed 🔲 Retired						
VIII. PRIOR COVERAGE / OTHER INSURANCE INFORMATIC	N						
IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE PROCESSING DELAYS.	THIS SECTION WILL CAUSE SIGNIFICANT CLAIMS						
□ 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	cy Covers: 🔲 Policy Holder Only 📋 Two Persons 🔲 Family						
4. Effective Date of Policy / / month day year							
 5. Service(s) Covered: A. Hospital Services B. Physician Services C. Major Medical (out-of-pocket expenses) D. Separate Drug Program Yes N Yes N Yes N 	o F. Eye / Vision Care Services O G. Mental Illness Services Yes No						
 Is coverage through an employer or other group? ☐ Yes ☐ If Yes, name of employer or other group 	No						
7. Is this coverage under COBRA? Yes No							
 To be completed if the parents live apart and provide medica Please indicate relationship to child(ren). 	l coverage for their child(ren):						
PARENT WITH COURT-ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S	PARENT WITH Parent's Name / Relationship CUSTODY OF						
MEDICAL EXPENSES Child's Name / Date of Birth	CHILD(REN) Child's Name / Date of Birth						

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 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 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 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

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc., and is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

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 CareFirst BlueCross BlueShield 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 BlueCross BlueShield 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 and Date	Email Address	Cell Phone Number	

By signing below, my dependents (spouse or domestic partner, and any other dependents) covered by CareFirst BlueCross BlueShield individually agree to electronic delivery of notices.

Dependent Name	Signature and Date	Email Address	Cell Phone Number
First BlueCross BlueShiel	d will not sell your email address of	or cell phone number to any th	ird party and we do not shar

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

CareFirst BlueCross BlueShield 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.

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*09 Farsi01 English10 French (Eu02 Albanian11 Greek03 Amharic12 Gujarati04 Arabic13 Hindi05 Burmese14 Italian06 Cantonese15 Korean07 Chinese (simplified & traditional)17 Portugues08 Creole (Haitian)17		20 Somali 21 Spanish (Latin America) 22 Tagalog (Filipino) 23 Urdu 24 Vietnamese 98 Other and unspecified	
	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 Sig	nature					Date	

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