

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

## BlueChoice Advantage Enrollment Form

(Maryland Groups not subject to Small Group Reform)  
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. Please return this form to your employer.
4. **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	Group Number _____
Effective Date Requested _____ / _____ / _____	Medical Option _____ Dental Option _____ Vision Option _____

**II. ENROLLEE**

Social Security Number	Date of Birth _____ / _____ / _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name	First Name	Middle Initial
Date of Hire _____ / _____ / _____	Occupation	Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired
Residence Address (Number and Street) _____ (City and State) _____ (Zip Code – 9-digit, if known) _____		
Home Phone (_____) _____	Work Phone (_____) _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married / Domestic Partner <input type="checkbox"/> Other <input type="checkbox"/> Separated <input type="checkbox"/> Divorced

**III. TYPE OF ENROLLMENT****CHECK ONE:** ☐ New ☐ Coverage Change**IV. TYPE OF COVERAGE**

To avoid delays in processing this form, please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section.

**CHECK ONE:**

- ☐ Individual
- ☐ Individual and Adult
- ☐ Individual and Child
- ☐ Individual and Children
- ☐ Family
- ☐ Coverage Complementary to Medicare (Individual only and benefit coverage only; not eligible for HSA)

**CHECK ONE:**

- ☐ [BlueChoice Advantage, Option \_\_\_\_]
- ☐ [BlueFund BlueChoice Advantage HRA, Option \_\_\_\_]
- ☐ [BlueFund BlueChoice Advantage HSA, Option \_\_\_\_]
- ☐ [BlueChoice Advantage HRA Compatible, Option \_\_\_\_]
- ☐ [BlueChoice Advantage HSA Compatible, Option \_\_\_\_]
- ☐ [BlueChoice Advantage 2.0, Option \_\_\_\_]
- ☐ [BlueFund BlueChoice Advantage 2.0 HRA, Option \_\_\_\_]
- ☐ [BlueFund BlueChoice Advantage 2.0 HSA, Option \_\_\_\_]
- ☐ [BlueChoice Advantage 2.0 HRA Compatible, Option \_\_\_\_]
- ☐ [BlueChoice Advantage 2.0 HSA Compatible, Option \_\_\_\_]

**CHECK ALL APPLICABLE:**

- ☐ [Dental HMO]
- ☐ [Preferred Dental]
- ☐ [Traditional Dental]
- ☐ [BlueDental Plus]
- ☐ [BlueDental EPO]
- ☐ [BlueDental Basic]
- ☐ [BlueVision Plus]

CareFirst BlueChoice, Inc., 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.

**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☐ REMOVE dependent(s) listed in Section VI due to \_\_\_\_\_☐ ADD spouse due to marriage on \_\_\_\_\_ (Date)

(Reason)

☐ ADD domestic partner on \_\_\_\_\_ (Date) on \_\_\_\_\_ (Date)☐ ADD child due to adoption on \_\_\_\_\_ (Date)  
or appointed legal guardian by court decree dated \_\_\_\_\_☐ CHANGE address to that shown in Section II☐ CHANGE my name from \_\_\_\_\_  
to that shown in Section II**(Note: Documentation of adoption or court-appointed  
legal guardianship must be provided)****VI. DEPENDENT INFORMATION**

<b>1</b>	<b>Spouse / Domestic Partner</b>	Name – (Last, First, MI)	Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>2</b>	<b>Child</b>	Name – (Last, First, MI)	Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<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
<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
<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

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

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

Dependent 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>
Dependent 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

\_\_\_\_\_  
**Parent's Name / Relationship**

MEDICAL EXPENSES

\_\_\_\_\_  
**Child's Name / Date of Birth**

PARENT  
WITH  
CUSTODY OF  
CHILD(REN)

\_\_\_\_\_  
**Parent's Name / Relationship**

\_\_\_\_\_  
**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 BlueChoice, Inc., and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution.

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.

**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 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

## 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	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.

## XI. RACE, ETHNICITY, LANGUAGE (this information is voluntary)

As required by Maryland law, CareFirst BlueChoice 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 you. The information is kept strictly confidential and will not be shared unless required by law.

Race	Ethnicity	Preferred Spoken Language*		
White/Caucasian	Hispanic/Latino/Spanish origin	01 English	09 Farsi	18 Russian
Black or African American		02 Albanian	10 French (European)	19 Serbian
American Indian or Alaska Native		03 Amharic	11 Greek	20 Somali
Asian		04 Arabic	12 Gujarati	21 Spanish (Latin America)
Native Hawaiian or Other Pacific Islander		05 Burmese	13 Hindi	22 Tagalog (Filipino)
Other – (To include Multi-Racial)		06 Cantonese	14 Italian	23 Urdu
Decline to answer		07 Chinese (simplified & traditional)	15 Korean	24 Vietnamese
Unknown – Could not be determined		08 Creole (Haitian)	16 Mandarin	98 Other and unspecified languages
			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 1					
Child 2					
Child 3					
Child 4					
Child 5					
Child 6					

Enrollee Signature

Date