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

BlueChoice Advantage Enrollment Form

(Virginia Groups)

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 ☐ 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

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 HMO]
☐[BlueVision *Plus*]

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
- ☐ ADD spouse due to marriage on ____________ (Date)
- ☐ ADD domestic partner 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)

- ☐ REMOVE dependent(s) listed in Section VI due to ______________________________ (Reason) on ____________ (Date)
- ☐ CHANGE address to that shown in Section II
- ☐ CHANGE my name from ______________________ to that shown in Section II

VI. DEPENDENT INFORMATION

1	**Spouse**	Name – (Last, First, MI)	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female
2	**Domestic Partner**	Name – (Last, First, MI)	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female
3	**Child**	Name – (Last, First, MI)	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female
4	**Child**	Name – (Last, First, MI)	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female
5	**Child**	Name – (Last, First, MI)	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female
6	**Child**	Name – (Last, First, MI)	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ 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? ☐ Yes ☐ No	**If Yes, Attach Student Certification Form**	Disabled? ☐ Yes ☐ No	**If Yes, Attach Disability Certification Form and Supporting Documentation**
Dependent Name – (Last, First, MI)	Full-Time Student? ☐ Yes ☐ No		Disabled? ☐ Yes ☐ 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	☐ 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
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	______________________ ***Parent's Name / Relationship*** ______________________ ***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 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 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.)

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.

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*
- 01 English
- 02 Albanian
- 03 Amharic
- 04 Arabic
- 05 Burmese
- 06 Cantonese
- 07 Chinese (simplified & traditional)
- 08 Creole (Haitian)
- 09 Farsi
- 10 French (European)
- 11 Greek
- 12 Gujarati
- 13 Hindi
- 14 Italian
- 15 Korean
- 16 Mandarin
- 17 Portuguese (Brazilian)
- 18 Russian
- 19 Serbian
- 20 Somali
- 21 Spanish (Latin America)
- 22 Tagalog (Filipino)
- 23 Urdu
- 24 Vietnamese
- 98 Other and unspecified languages
- 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