CareFirst BlueChoice

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

Small Employer Group Options Enrollment Form

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. You **MUST** include a Primary Care Physician name and code number for each dependent listed. The Physician Code # is located in the Provider Directory. **Failure to provide this information may delay in-network services.**
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

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

Email Address

Primary Care Physician	Physician Code Number	Current Patient ☐ Yes ☐ No

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

IF ENROLLING FOR MEDICAL COVERAGE, CHECK ONE:

- ☐ BlueChoice, Option ____
- ☐ BlueChoice *Open Access*, Option ____
- ☐ BlueChoice Opt-Out *Open Access*, Option ____
- ☐ BlueChoice Opt-Out *Plus Open Access*, Option ____
- ☐ BlueFund BlueChoice *Open Access* HRA, Option ____
- ☐ BlueFund BlueChoice *Open Access* HSA, Option ____
- ☐ BlueFund BlueChoice Opt-Out *Plus Open Access* HRA, Option ____
- ☐ BlueFund BlueChoice Opt-Out *Plus Open Access* HSA, Option ____
- ☐ BlueChoice *Open Access* HSA Compatible, Option ____
- ☐ BlueChoice Opt-Out *Plus Open Access* HSA Compatible, Option ____

CHECK ALL APPLICABLE:

- ☐ Dental HMO
- ☐ Dental HMO Opt-Out
- ☐ Preferred Dental
- ☐ Traditional Dental
- ☐ 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
- ☐ CHANGE Primary Care Physician to that shown in Section II for enrollee or Section VI for dependent(s)

VI. DEPENDENT INFORMATION

1	**Spouse / Domestic Partner**	Name – (Last, First, MI)		Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	Email Address	
		Primary Care Physician		Physician Code Number	Current Patient ☐ Yes ☐ No
2	**Child**	Name – (Last, First, MI)		Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	Email Address	
		Primary Care Physician		Physician Code Number	Current Patient ☐ Yes ☐ No
3	**Child**	Name – (Last, First, MI)		Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	Email Address	
		Primary Care Physician		Physician Code Number	Current Patient ☐ Yes ☐ No
4	**Child**	Name – (Last, First, MI)		Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	Email Address	
		Primary Care Physician		Physician Code Number	Current Patient ☐ Yes ☐ No
5	**Child**	Name – (Last, First, MI)		Social Security Number	
		Date of Birth / /	Sex ☐ Male ☐ Female	Email Address	
		Primary Care Physician		Physician Code Number	Current Patient ☐ Yes ☐ No

COMPLETE ONLY IF DEPENDENT CHILD IS DISABLED

Dependent Name – (Last, First, MI)	**Attach Disability Certification Form and Supporting Documentation**
Dependent Name – (Last, First, MI)	

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 ___ /___ /___

Name _____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No. _____ Eligible for: ☐ Part A Eff. Date ___ /___ /___ ☐ Part B Eff. Date ___ /___ /___

ENROLLEE 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 children.
   Please indicate relationship to children:

PARENT WITH COURT-ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES	_____ *Parent's Name / Relationship*	PARENT WITH CUSTODY OF CHILD(REN)	_____ *Parent's Name / Relationship*
	_____ *Child's Name / Date of Birth*		_____ *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 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 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

You can receive electronic notices via email instead of paper notices for your CareFirst BlueChoice, Inc. health care coverage by providing your consent below.

- These will include but are not limited to:
  - Explanation of Benefits alerts
  - Appeal decision alerts
  - 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.

- You may change your email 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 request a paper copy of electronic notices at anytime by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically, 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).

By signing below, I hereby agree to electronic delivery of notices and documents.

Member Name	**Signature**

By signing below, my spouse and any dependents covered by CareFirst BlueChoice, Inc. individually agree to electronic delivery of notices and documents:

Spouse/Dependent Name	**Signature**

CareFirst BlueChoice, Inc. will not sell your email address to any third party and we do not share it with third parties except for CareFirst BlueChoice, Inc. vendors that perform functions on our behalf or to comply with the law.