



CareFirst of Maryland, Inc.

10455 Mill Run Circle
Owings Mills, MD 21117

Enrollment Form
(Maryland Small Groups)

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	Effective Date Requested / /	Group Number
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II. ENROLLEE

Social Security Number	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Last Name	First Name	Middle Initial
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Date of Hire / /	Occupation	Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired
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Residence Address (Number and Street)	(City and State)	(Zip Code – 9-digit, if known)
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Home Phone ()	Work Phone ()	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
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Tobacco Usage*
 Yes No
**Tobacco usage means use of tobacco, including cigarettes, on average four or more times per week within no longer than the past 6 months.*

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:

<input type="checkbox"/> BluePreferred PPO HSA/HRA \$2,000-SE	<input type="checkbox"/> HealthyBlue PPO \$500
<input type="checkbox"/> BluePreferred PPO HSA/HRA \$4,000-SE	<input type="checkbox"/> HealthyBlue PPO \$1,000
<input type="checkbox"/> BluePreferred PPO HSA/HRA \$2,000	
<input type="checkbox"/> BluePreferred PPO HSA/HRA \$1,600	
<input type="checkbox"/> BluePreferred PPO HSA/HRA \$4,000	
<input type="checkbox"/> BluePreferred PPO \$1,000-SE	
<input type="checkbox"/> BluePreferred PPO 100%/80%-SE	
<input type="checkbox"/> BluePreferred PPO \$250	
<input type="checkbox"/> BluePreferred PPO \$1,000	
<input type="checkbox"/> BluePreferred PPO \$2,000	
<input type="checkbox"/> BluePreferred PPO \$1,400	
<input type="checkbox"/> HealthyBlue PPO HSA/HRA \$2,000	
<input type="checkbox"/> HealthyBlue PPO \$1,500	

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 | <input type="checkbox"/> REMOVE dependent(s) listed in Section VI due to _____ (Reason) |
| <input type="checkbox"/> ADD spouse due to marriage on _____ (Date) | _____ (Date) |
| <input type="checkbox"/> ADD domestic partner on _____ (Date) | _____ (Date) |
| <input type="checkbox"/> ADD child due to adoption on _____ (Date) or appointed legal guardian by court decree dated _____ | <input type="checkbox"/> CHANGE address to that shown in Section II |
| | <input type="checkbox"/> 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

1	Spouse	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Usage* <input type="checkbox"/> Yes <input type="checkbox"/> No
2	Domestic Partner	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Usage* <input type="checkbox"/> Yes <input type="checkbox"/> No
3	Child	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Usage* <input type="checkbox"/> Yes <input type="checkbox"/> No
4	Child	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Usage* <input type="checkbox"/> Yes <input type="checkbox"/> No
5	Child	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Usage* <input type="checkbox"/> Yes <input type="checkbox"/> No
6	Child	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Usage* <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 Name – (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Attach Student Certification Form	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Attach Disability Certification Form and Supporting Documentation
Child 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 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 WITH CUSTODY OF CHILD(REN)	_____
	<i>Parent's Name / Relationship</i>		<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 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 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 we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in a delay in the effective date of coverage.

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 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	Email Address	Cell Phone Number

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

Spouse/Partner/ Dependent Name	Signature	Email Address	Cell Phone Number

CareFirst BlueCross BlueShield 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 BlueCross BlueShield vendors that perform functions on our behalf or to comply with the law.