

Individual BluePreferred-Saver Application

(District of Columbia Residents)



Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065

ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

INSTRUCTIONS
<p>1. Please fill out all applicable spaces on this application. Print or type all information.</p> <p>2. Sign and return this application in the postage-paid return envelope if provided, or mail to CareFirst BlueCross BlueShield Individual Market Division/RR291 10455 Mill Run Circle Owings Mills, MD 21117-9685</p> <p><i>Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. If incomplete, the application will be returned and delay your coverage.</i></p>



1. APPLICANT INFORMATION (The oldest applicant will be the Subscriber)					
Last Name		First Name		Initial	Social Security #
Residence Address: (Number and Street, Apt. #)			City and State	Zip Code (9-digit, if known)	
Billing Address, if different from Residence Address: (Number and Street, Apt. #)			City and State	Zip Code (9-digit, if known)	
Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Height	Weight
Home Phone ()	Work Phone ()	E-mail Address			

2. COVERAGE SELECTION (Check one)
<input type="checkbox"/> Individual - Provides coverage for one person <input type="checkbox"/> Individual & Child(ren) - Provides coverage for an individual and eligible dependent(s) <input type="checkbox"/> Individual & Adult - Provides coverage for two eligible adults <input type="checkbox"/> Family - Provides coverage for two eligible adults and eligible dependent(s)

3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child(ren), Individual & Adult or Family Coverage									
Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	HT (in.)	WT (lbs.)	
Spouse/Domestic Partner						<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F			

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:			
Sub-Agent/Sub-Agency:			
Writing Agent:			

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.

4. COVERAGE LEVEL:

CHECK ONE:	Individual Deductible		Coverage Level		Individual Out-of-Pocket Limit	
	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)
<input type="checkbox"/>	\$2,500	\$5,000	70%	60%	\$5,000	\$10,000
<input type="checkbox"/>	\$5,000	\$10,000	100%	80%	\$5,000	\$12,500
<input type="checkbox"/>	\$10,000	\$12,500	100%	80%	\$10,000	\$15,000

MATERNITY BENEFITS: Check this box if you wish to include benefits for maternity services (additional cost). Yes

5. OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

YES NO

1. Is anyone listed on this application eligible for Medicare? YES NO

If yes, please provide the following:

Name of family member(s) _____ Medicare No. _____ Effective Date _____

2. Is anyone listed on this application covered by other health insurance, including other Blue Cross and Blue Shield coverage? . YES NO

If yes, please provide the following:

Name of family member(s) _____ Insurance Company _____

Policy Number and Type _____ Effective Date _____

If you are accepted, will your new CareFirst BlueCross BlueShield coverage replace your existing policy? YES NO

3. Has anyone listed on this application been without health insurance for the past 12 months or longer? YES NO

If yes, please list name(s): _____

6. HEALTH EVALUATION

PLEASE COMPLETE SECTIONS A, B, AND C. CHECK EACH ITEM "YES" OR "NO".

Answering yes will not necessarily result in the rejection of your application.

YES NO

Have you or any family member named in this application had a physical examination within the past five years? YES NO

SECTION 6A – If any person included in this application is presently using or has used medication or prescription drugs in the past 5 years, please provide the following information.

Name of Family Member	Illness or Condition	Medication	Date of Last Treatment	How Often Taken	Attending Physician Name and Address

6. HEALTH EVALUATION (Continued)

SECTION 6B — To the best of your knowledge or belief, has any person named in this application had within the last five years, or does such person now have, any of the following: **YES NO**

1. Cancer, tumor or other growth (malignant or benign)
2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test) ...
3. Kidney stones, kidney or bladder condition, urinary frequency or burning
4. Goiter, thyroid condition, diabetes
5. Seizure disorder, central nervous system disorder, multiple sclerosis
6. Substance abuse (drug or alcohol dependency, abuse or addiction)
7. Use of illicit drugs.
8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition
9. Cataract or other eye condition
10. Tuberculosis, lung condition, asthma, bronchitis
11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition.
12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)
13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, breast condition
14. (Female) Is currently pregnant; expected date of delivery: ____/____/____
15. (Male) Prostate condition, reproductive system disorders.
16. Do you or your spouse/partner have infertility or any disorder related to infertility.
17. Have you or your spouse/partner received any treatment or diagnostic “work-up” related to infertility.
18. Have you been told that you have high or elevated cholesterol, lipids or triglycerides
19. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder
20. Sexually transmitted diseases
21. Anemia, blood disorders
22. Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or prescription medication for a medical condition NOT listed above in items 1-21?
23. Had any known departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought?

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” – Or your application will be returned.

NOTE: FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN VOIDING OF MEMBERSHIP AND DENIAL OF BENEFITS.

SECTION 6C — If you have checked “YES” to any part of SECTION 6B, for each box checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Patient’s Name	Question Number	Diagnosis or Condition	Duration Dates	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician’s/hospital’s name.	Recovery (Check only one box.)
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL

7. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request, from Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst).

This information is subject to verification. To do so I authorize any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company to release my "Medical Information" to Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) or CareFirst's vendors or representatives. I further authorize any vendor who receives "Medical Information" from any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company to release my "Medical Information" to CareFirst. I understand that my Medical Information consists of any diagnoses, treatment, prescriptions from a pharmacy, or any other medically related information about me. I authorize CareFirst to use my Medical Information for underwriting and to determine my eligibility for insurance benefits. I understand this authorization will remain in effect for one year from the date signed. I understand that I have the right to cancel this authorization at any time, in writing, except to the extent that CareFirst has already taken action in reliance on this authorization. I also understand that CareFirst's Notice of Privacy Practices includes information pertaining to authorizations and to requirements of revocation. A copy of the Notice may be obtained by contacting the CareFirst's Privacy Office. CareFirst will not use or disclose the Medical Information for any purposes other than those listed above except as may be required by law. CareFirst is required to tell you by law that information disclosed pursuant to this authorization may be subject to re-disclosure and that under some limited circumstances will no longer be protected by federal privacy regulations.

If CareFirst determines that additional information is needed, I will receive an authorization to release that information. Failure to execute an authorization may result in the denial of my application for coverage. Additionally I understand that failure to complete any section of this application, including signing below, may delay the processing of my application.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst policy. I understand that a medically underwritten policy is only issued under the conditions that the health of all persons named on the application remains as stated above. I also understand that failure to enter accurate, complete and updated medical information may result in the denial of all benefits, cancellation or voiding of my policy.

I will update CareFirst if there have been any changes in health concerning any person listed in this application that occur prior to acceptance of this application by CareFirst.

By signing this application, I hereby authorize CareFirst BlueCross BlueShield to disseminate and share non-health questionnaire information contained on this application with the Health Savings Account preferred bank(s) affiliated with CareFirst BlueCross BlueShield. I understand that dissemination of information to any such bank is at my direction and with my full understanding. Further that dissemination of information on this application, excluding health questionnaire information, is necessary in order to effectuate the establishment of a Health Savings Account in my name with the bank. The authorization shall continue until my enrollment with CareFirst BlueCross BlueShield terminates or at any time that I provide a written instruction to CareFirst BlueCross BlueShield revoking this authorization or if this authorization terminates by operation of law.

If you do not want information on this application shared with the Health Savings Account preferred bank(s) please check here.

IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY OR EXCLUDED UNDER THIS AGREEMENT, PLEASE CONTACT A MEMBERSHIP SERVICES REPRESENTATIVE BEFORE SIGNING THIS APPLICATION.

An applicant or dependent whose application is denied by CareFirst BlueCross BlueShield due to medical underwriting may not submit a subsequent application for enrollment within ninety (90) days of the denial.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, CareFirst may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signature of Applicant 1:* X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____
(Spouse/Partner)

*Rates are based on the age of the Subscriber (oldest applicant).

NOTE: applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

Parent or Legal Guardian's Signature: X _____ Date: _____

For Office Use Only:

Re-sign and re-date below only if box is checked.

Signature of Applicant 1: X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____

(Spouse/Partner)