

# Individual BluePreferred Application

(Maryland Residents)



OFFICE USE ONLY:

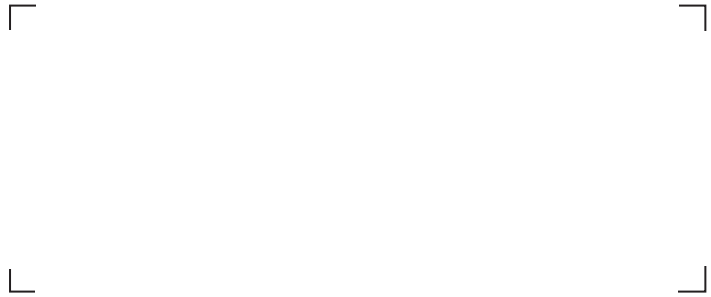
Group Hospitalization and Medical Services, Inc.  
840 First Street, NE, Washington, DC 20065

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

## INSTRUCTIONS

- Please fill out all applicable spaces on this application. Print or type all information.
- 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**

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.*



## 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"/> Partner		Height	Weight
Home Phone ( )	Work Phone ( )	E-mail Address			

## 2. COVERAGE SELECTION: (Check one)

- Individual** - Provides coverage for one person  
 **Individual & Child(ren)** - Provides coverage for an individual and eligible dependent(s)  
 **Individual & Adult** - Provides coverage for two eligible adults  
 **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	HEIGHT (in.)	WEIGHT (lbs.)
Spouse/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		
Dependent 5						<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:			

#### 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"/>	\$100	\$300	90%	70%	\$2,500	\$5,000
<input type="checkbox"/>	\$300	\$500	90%	70%	\$2,500	\$5,000
<input type="checkbox"/>	\$300	\$500	80%	60%	\$2,500	\$5,000
<input type="checkbox"/>	\$500	\$750	80%	60%	\$2,500	\$4,000

**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?<br>If yes, please provide the following:<br>Name of family member(s) _____ Medicare No _____ Effective Date _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is anyone listed on this application covered by other health insurance, including other Blue Cross and Blue Shield coverage?<br>If yes, please provide the following:<br>Name of family member(s) _____ Insurance Company _____<br>Policy Number and Type _____ Effective Date _____<br>If you are accepted, will your new CareFirst BlueCross BlueShield coverage replace your existing policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has anyone listed on this application been without health insurance for the past 12-months or longer?<br>If yes, please list name(s): _____  | <input type="checkbox"/> | <input type="checkbox"/> |

#### 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.

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

**SECTION 6B – To the best of your knowledge and 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).....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test).... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Kidney stones, kidney or bladder condition, urinary frequency or burning.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Goiter, thyroid condition, diabetes.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Seizure disorder, central nervous system disorder, multiple sclerosis.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Substance abuse (drug or alcohol dependency, abuse or addiction) .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**6. HEALTH EVALUATION (Continued)**

	YES	NO
7. Use of illicit drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Cataract or other eye condition.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Tuberculosis, lung condition, asthma, bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke).....	<input type="checkbox"/>	<input type="checkbox"/>
13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, breast condition.....	<input type="checkbox"/>	<input type="checkbox"/>
14. (Female) Is currently pregnant; expected date of delivery: ____/____/____ .....	<input type="checkbox"/>	<input type="checkbox"/>
15. (Male) Prostate condition, reproductive system disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you or your spouse/partner have known infertility or any known disorder related to infertility.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you or your spouse/partner received any treatment or diagnostic “work-up” related to infertility.....	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you been told that you have high or elevated cholesterol, lipids or triglycerides.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
20. Sexually transmitted diseases.....	<input type="checkbox"/>	<input type="checkbox"/>
21. Anemia, blood disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
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?.....	<input type="checkbox"/>	<input type="checkbox"/>
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? .....	<input type="checkbox"/>	<input type="checkbox"/>

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

**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.**

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

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
			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.

**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 due to medical underwriting may not submit a subsequent Application for enrollment within ninety (90) days of the denial.

**WARNING: 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.**

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)