

ENROLLMENT FORM (District of Columbia Groups)



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

1 EMPLOYER INFORMATION: To be completed by the employer.

Employer/Group Administrator	Group Number:
Effective Date Requested __ __ / __ __ / __ __	Medical: _____ Dental: _____
Check all that apply	Medical Option: _____
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired	Vision: _____

2 TYPE OF REQUEST

<input type="checkbox"/> New Subscriber <input type="checkbox"/> Coverage Change <input type="checkbox"/> Add Dependents <input type="checkbox"/> Delete Dependents <input type="checkbox"/> Any information change (name or address change)	Are you enrolling eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
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3 SUBSCRIBER INFORMATION

Social Security Number __ - __ - ____	Subscriber Last Name	First Name	Middle Initial
Date of Birth __ / __ / __	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire: __ / __ / __	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married/Partner <input type="checkbox"/> Other <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced Effective Date of Status __ / __ / __
Street Address	Apt.	City	County State
Country	Zip	Home Phone () - - - - -	Work Phone () - - - - -

4 CHANGE TO EXISTING COVERAGE

Dependents affected by adds or deletes must be listed in Section 5 Dependent Information.

Identification Number, if different from Social Security Number _____

ADD dependent(s) listed in Section 5

ADD spouse due to marriage on _____ (Date)

ADD 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. CareFirst BlueCross BlueShield will pay the cost of the documentation required to provide proof of adoption or court-appointed legal guardianship.)

REMOVE dependent(s) listed in Section 5 due to _____ (Reason) _____ (Date)

CHANGE address to that shown in Section 3 above

CHANGE my name from _____ to that shown in Section 3

5 SUBSCRIBER & DEPENDENT INFORMATION: Please list all persons to be covered.

COVERAGE LEVEL – Please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section to avoid delays in processing this Enrollment Form.

COVERAGE LEVELS OF SUBSCRIBER AND DEPENDENTS, IF APPLICABLE

<input type="checkbox"/> Individual	<input type="checkbox"/> Individual and Adult (Two-Party Coverage)
<input type="checkbox"/> Individual and Child	<input type="checkbox"/> Individual and Children
<input type="checkbox"/> Family	
<input type="checkbox"/> Coverage Complementary to Medicare (Individual Only)	

SUBSCRIBER INFORMATION

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
			<input type="checkbox"/> Medical <input type="checkbox"/> Traditional Dental <input type="checkbox"/> Preferred Dental <input type="checkbox"/> BlueVision Plus	Subscriber			

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5 SUBSCRIBER & DEPENDENT INFORMATION (continued)

DEPENDENT INFORMATION: If the subscriber has more than four dependents, please list the additional dependents on a separate Enrollment Form.

Last	First	MI	Coverage Level	Relationship	Sex	Date of Birth	Social Security Number
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus				
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus				
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus				
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus				

Is anyone listed above a student or disabled? YES NO

If the answer is YES, please list the name of the person _____

If a full-time student, please attach student certification form. If yes, disabled, please attach disability certification form and supporting documentation.

6 MEDICARE INFORMATION: To be completed if applicable.

Are You Eligible for Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: ____ - ____ - ____ - ____	Hosp. Eff. Date (Part A) ____ / ____ / ____	Med. Eff. Date (Part B) ____ / ____ / ____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				
Spouse/Partner	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: ____ - ____ - ____ - ____	Hosp. Eff. Date (Part A) ____ / ____ / ____	Med. Eff. Date (Part B) ____ / ____ / ____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				
Child/Dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: ____ - ____ - ____ - ____	Hosp. Eff. Date (Part A) ____ / ____ / ____	Med. Eff. Date (Part B) ____ / ____ / ____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				

7 OTHER HEALTH INSURANCE INFORMATION

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

Is any person listed on the Enrollment Form covered by another health care plan, HMO, or Medicare? Yes No

If yes, will this coverage be continued? Yes No If no, please provide the cancellation date ____ / ____ / ____

Policyholder's Name	Phone Number of Other Insurer () ____ - ____ - ____	Date of Birth ____ / ____ / ____
Name and Address of Insurance Company		
Policy Number	Termination Date ____ / ____ / ____	Effective Date of Policy ____ / ____ / ____
Services Covered: <input type="checkbox"/> Hospital Services <input type="checkbox"/> Physician Services <input type="checkbox"/> Major Medical <input type="checkbox"/> Drug Program <input type="checkbox"/> Dental Services <input type="checkbox"/> Eye/Vision Care Services <input type="checkbox"/> HMO <input type="checkbox"/> Mental Illness Services		
Does this policy cover you? <input type="checkbox"/> Yes <input type="checkbox"/> No Your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No Your children? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list name(s) of children covered _____		
Is this coverage under COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason for cancellation _____		
Cancellation Date ____ / ____ / ____		

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this Form is accepted, 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 subscription charges to my employer.

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, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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 CLAIMS PAYMENT.

_____/_____/_____
Subscriber's Signature Date Dependent's Signature /_____/_____
_____/_____/_____
Authorization Signature Date