



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

Enrollment Form

(District of Columbia Groups)

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
Last Name	First Name	Middle Initial
Date of Hire / /	Occupation	Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired
Residence Address (Number and Street) (City and State) (Zip Code – 9-digit, if known)		
Home Phone ()	Work Phone ()	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married / Domestic Partner <input type="checkbox"/> Other <input type="checkbox"/> Separated <input type="checkbox"/> Divorced

III. TYPE OF ENROLLMENT

CHECK ONE: New New due to confirmation of pregnancy by a healthcare provider on _____(Date)
 (must be within the last 90 days) 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:

<input type="checkbox"/> Individual <input type="checkbox"/> Individual and Adult <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 and benefit coverage only; Other not eligible for HSA)	IF ENROLLING FOR MEDICAL COVERAGE, CHECK ONE: <input type="checkbox"/> BluePreferred, Option _____ <input type="checkbox"/> BlueFund BluePreferred HRA, Option _____ <input type="checkbox"/> BlueFund BluePreferred HSA, Option _____ <input type="checkbox"/> BluePreferred HRA Compatible, Option____ <input type="checkbox"/> BluePreferred HSA Compatible, Option ____ <input type="checkbox"/> Other	CHECK ALL APPLICABLE: <input type="checkbox"/> Preferred Dental <input type="checkbox"/> Traditional Dental <input type="checkbox"/> BlueVision Plus
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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"/> ADD spouse due to marriage on _____(Date) <input type="checkbox"/> ADD domestic partner on _____(Date) <input type="checkbox"/> ADD dependent(s) due to confirmation of pregnancy by a healthcare provider on _____(Date) <input type="checkbox"/> ADD child due to adoption on _____(Date) or appointed legal guardian by court decree dated _____	<input type="checkbox"/> REMOVE dependent(s) listed in Section VI due to _____(Reason) on _____(Date) <input type="checkbox"/> CHANGE address to that shown in Section II <input type="checkbox"/> CHANGE my name from _____ to that shown in Section II
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(Note: Documentation of adoption or court-appointed legal guardianship must be provided)

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VI. DEPENDENT INFORMATION

1	Spouse/ Domestic Partner/ Civil Union Partner	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Social Security Number			
2	Child	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Social Security Number			
3	Child	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Social Security Number			
4	Child	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Social Security Number			
5	Child	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Social Security Number			

COMPLETE ONLY IF DEPENDENT CHILD IS A STUDENT OR DISABLED (AGE 26 OR OLDER)

If dependent child is a student age 26 or older, please confirm coverage with your employer prior to completing this section.

Dependent 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
Dependent 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | E. Dental | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. Physician Services | <input type="checkbox"/> Yes <input type="checkbox"/> No | F. Eye / Vision Care Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Major Medical (out-of-pocket expenses) | <input type="checkbox"/> Yes <input type="checkbox"/> No | G. Mental Illness Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. Separate Drug Program | <input type="checkbox"/> Yes <input type="checkbox"/> No | H. HMO | <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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 BlueCross BlueShield 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 the processing of your form and/or claims payment.

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.

XI. RACE, ETHNICITY, LANGUAGE (This information is voluntary.)

CareFirst BlueCross BlueShield is asking its members to voluntarily provide their race, ethnicity, and language attributes. The information provided, while voluntary, will assist us to improve quality of care and access to care, thereby reducing health care disparities and promoting better health outcomes. The information you provide will not have a negative impact on any services we provide to you. The information is kept strictly confidential and will not be shared unless we are required by law to disclose it.

- | | | | | |
|---|--------------------------------|---------------------------------------|---------------------------|------------------------------------|
| Race | Ethnicity | Preferred Spoken Language* | 09 Farsi | 18 Russian |
| White/Caucasian | Hispanic/Latino/Spanish origin | 01 English | 10 French (European) | 19 Serbian |
| Black or African American | | 02 Albanian | 11 Greek | 20 Somali |
| American Indian or Alaska Native | | 03 Amharic | 12 Gujarati | 21 Spanish (Latin America) |
| Asian | | 04 Arabic | 13 Hindi | 22 Tagalog (Filipino) |
| Native Hawaiian or Other Pacific Islander | | 05 Burmese | 14 Italian | 23 Urdu |
| Other – (To include Multi-Racial) | | 06 Cantonese | 15 Korean | 24 Vietnamese |
| Decline to answer | | 07 Chinese (simplified & traditional) | 16 Mandarin | 98 Other and unspecified languages |
| Unknown – Could not be determined | | 08 Creole (Haitian) | 17 Portuguese (Brazilian) | 99 Unknown |

Last Name	First Name	Race	Ethnicity	Country of Origin	Preferred Spoken Language (*specify number from above)
Enrollee					
Spouse/ Domestic Partner/ Civil Union Partner					
Child					
Child					
Child					
Child					
Child					

Enrollee Signature

Date