

Group Hospitalization and Medical Services, Inc.

840 First Street, NE
Washington, DC 20065

Enrollment Form
Dental and Vision Plans
(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.

I. EMPLOYER INFORMATION To be completed by the employer

| | | |
|--------------------------------|---------------------------------|--------------|
| Employer / Group Administrator | Effective Date Requested / / | Group Number |
|--------------------------------|---------------------------------|--------------|

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 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.

| | |
|--|--|
| <p>CHECK ONE:</p> <p><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</p> | <p>CHECK ALL APPLICABLE:</p> <p><input type="checkbox"/> BlueDental Plus <input type="checkbox"/> BlueVision Plus <input type="checkbox"/> BlueDental EPO <input type="checkbox"/> BlueDental Basic <input type="checkbox"/> Preferred Dental <input type="checkbox"/> Traditional Dental</p> |
|--|--|

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: _____

| | |
|--|--|
| <p><input type="checkbox"/> ADD dependent(s) listed in Section VI</p> <p><input type="checkbox"/> ADD spouse due to marriage on _____ (Date)</p> <p><input type="checkbox"/> ADD domestic partner/civil union partner on _____ (Date)</p> <p><input type="checkbox"/> ADD child due to adoption on _____ (Date) or appointed legal guardian by court decree dated _____</p> <p>(Note: Documentation of adoption or court-appointed legal guardianship must be provided)</p> | <p><input type="checkbox"/> REMOVE dependent(s) listed in Section VI due to _____ (Reason)</p> <p>on _____ (Date)</p> <p><input type="checkbox"/> CHANGE address to that shown in Section II</p> <p><input type="checkbox"/> CHANGE my name from _____ to that shown in Section II</p> |
|--|--|

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VI. DEPENDENT INFORMATION

| | | | | | |
|---|--|--------------------------|---|----------------------|---|
| 1 | Spouse / Domestic Partner/ Civil Union Partner | Name – (Last, First, MI) | Coverage Level <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"/> 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"/> 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"/> 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"/> 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 | |

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IX. 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/ Domestic Partner/ Civil Union 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.

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