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
- 3. Please return this form to your employer.

and date.							
I. EMPLOYER INFO	RMATION	To be completed by the emp	oloye	er			
Employer / Group Administrator			Effective Date Requested		Group Number		
II. ENROLLEE							
Social Security Numb	er	[Date of Birth			Sex ☐ Male ☐ Femal	e
Last Name		F	First I	Name		Middle In	itial
Date of Hire	Occupation	1				ment Status Time 🗌 Part-Time	Retired
Residence Address (Number and	d Street) (City	and State)		(Zip Code – 9-di	git, if known)
Home Phone ()		Work Phone ()		Marital Status		e ☐ Married / Dom ☐ Separated ☐	
III. TYPE OF ENROL	LMENT						
CHECK ONE: Ne	w 🗌 Cover	age Change					
IV. TYPE OF COVER	RAGE						
and coverage levels CHECK ONE: Individual Individual and Ad Individual and Cl Individual and Cl Family	s offered b dult nild nildren	this form, please confirm by your employer prior to co CHECK ALL APPLICABLE: BlueDental Plus BlueDental EPO BlueDental Basic Preferred Dental Traditional Dental	mpl			ills of the benefit	options
V. CHANGE TO EXIS							
-	-	ns or deletions must be liste	d in	Section VI - Dep	endent I	nformation.	
☐ ADD dependent(s) ☐ ADD spouse due t ☐ ADD domestic par ☐ ADD child due to a appointed legal gu	listed in Se o marriage of tner/civil united adoption on cardian by co	on (Date) on partner on (Date) (Date) or		on	(Dat ss to that me from	e) shown in Section I	(Reason)
legal guardianshi							

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

VI	. DEPEND	DENT INFORMATION						
1	Spouse / Domestic Partner/ Civil	Name – (Last, First, MI)		Coverage Dental BlueVis	Level sion <i>Plus</i>	Date of Birth	/	Sex Male Female
	Union Partner	Social Security Number						
2	Child	Name – (Last, First, MI)		Coverage Dental BlueVis	Level sion <i>Plus</i>	Date of Birth	/	Sex Male Female
		Social Security Number			,			
3	Child	Name – (Last, First, MI)		Coverage Dental BlueVis		Date of Birth	/	Sex Male Female
		Social Security Number			,			
4	Child	Name – (Last, First, MI)		Coverage Dental BlueVis	Level sion <i>Plus</i>	Date of Birth	/	Sex Male Female
		Social Security Number						
	Child	Name – (Last, First, MI)		Coverage Dental BlueVis		Date of Birth	/	Sex Male Female
5		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) ☐ Yes ☐ No		Full-Time	Student?	If Yes, Attach	Disabled? ☐ Yes ☐ No	Attac	If Yes, h Disability rtification
Dependent Name – (Last, First, MI)		Jame – (Last, First, MI)	Full-Time Yes No	Student?	Student Certification Form	Disabled? Yes No	Form and Supporting Documentation	

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VII. 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						
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 Yes No E. Dental Yes No B. Physician Services Yes No F. Eye / Vision Care Services Yes No C. Major Medical (out-of-pocket expenses) Yes No No H. HMO Yes No D. Separate Drug Program Yes No H. HMO Yes 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 Parent's Name / Relationship RESPONSIBILITY FOR CHILD(REN)'S Parent's Name / Relationship CUSTODY OF						
MEDICAL EXPENSES Child's Name / Date of Birth CHILD(REN) Child's Name / Date of Birth						
VIII. 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						

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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.

	y 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 sig	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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