

# Individual BluePreferred Application

(District of Columbia Residents)



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

**OFFICE USE ONLY:**

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.

*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**

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)				(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/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)

COVERAGE LEVEL DESIRED:

CHECK ONE:	Deductible		Coverage Level		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	\$600	90%	70%	\$2,500	\$5,000
<input type="checkbox"/>	\$300	\$600	80%	60%	\$2,500	\$5,000
<input type="checkbox"/>	\$500	\$1,000	80%	60%	\$2,500	\$5,000
<input type="checkbox"/>	\$750	\$1,500	80%	60%	\$3,500	\$7,000
<input type="checkbox"/>	\$2,500	\$5,000	80%	60%	\$5,000	\$7,500

**MATERNITY BENEFITS:** Check this box if you wish to include benefits for maternity services (additional cost).  Yes

<b>FOR BROKER USE ONLY:</b>	<b>Name:</b>	<b>SSN/Tax ID #:</b>	<b>CareFirst-Assigned ID#:</b>
<b>Contracted Broker:</b>			
<b>Sub-Agent/Sub-Agency:</b>			
<b>Writing Agent:</b>			

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**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	HT (in.)	WT (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		

**4. 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? .....

If yes, please provide the following:

Name of family member(s) \_\_\_\_\_ Medicare No. \_\_\_\_\_ Effective Date \_\_\_\_\_

2. Is anyone listed on this application covered by other health insurance, including other Blue Cross and Blue Shield coverage? .....

If yes, please provide the following:

Name of family member(s) \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy Number and Type \_\_\_\_\_ Effective Date \_\_\_\_\_

If you are accepted, will your new CareFirst BlueCross BlueShield coverage replace your existing policy? .....

3. Has anyone listed on this application been without health insurance for the past 12-months or longer? .....

If yes, please list name(s): \_\_\_\_\_

**5. 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.

**YES NO**

Have you or any family member named in the accompanying application had a physical examination within the past five years? .....

**SECTION 5A — To the best of your knowledge or 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) .....

2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test) .....

3. Kidney stones, kidney or bladder condition, urinary frequency or burning .....

**5. HEALTH EVALUATION (Continued)**

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 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"/> |
| 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, infertility, 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, infertility .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Sexually transmitted diseases .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Anemia, blood disorders .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. 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 1-18? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. 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 5B — If you have checked “YES” to any part of SECTION 5A, 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.**

Patient's First 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

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

**5. HEALTH EVALUATION (Continued)**

**SECTION 5C — If any person included in this application is presently using medication or prescription drugs, please provide the following information.**

Name of Family Member	Illness or Condition	Date of Last Treatment	Operation (Yes or No)	Attending Physician Name and Address

**6. 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. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

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 occurs 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.**

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

Signature of Applicant 1: \* **X** \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Applicant 2: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Re-sign and re-date below **only** if box is checked.

Signature of Applicant 1: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Applicant 2: **X** \_\_\_\_\_ Date: \_\_\_\_\_

\* Rates are based on the age of the Subscriber.

**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: \_\_\_\_\_