Individual BluePreferred Application

(Virginia Residents)

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

OFFICE USE ONLY:

ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. 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.***

TYPE OF ENROLLMENT (CHECK ONE)

☐ Underwritten ☐ Underwritten (First choice) or HIPAA (Second choice)

☐ HIPAA

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 ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	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 (In-Network)	Deductible (Out-of-Network)	Coverage Level (In-Network)	Coverage Level (Out-of-Network)	Out-of-Pocket Limit (In-Network)	Out-of-Pocket Limit (Out-of-Network)
☐	$100	$300	90%	70%	$2,500	$5,000
☐	$300	$600	90%	70%	$2,500	$5,000
☐	$300	$600	80%	60%	$2,500	$5,000
☐	$500	$1,000	80%	60%	$2,500	$5,000
☐	$750	$1,500	80%	60%	$3,500	$7,000
☐	$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

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

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

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						☐ M ☐ F		
Dependent 1						☐ M ☐ F		
Dependent 2						☐ M ☐ F		
Dependent 3						☐ M ☐ F		
Dependent 4						☐ M ☐ F		
Dependent 5						☐ M ☐ 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 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 BluePreferred 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. HIPAA ELIGIBILITY INFORMATION

YES NO

1. Are any applicant(s) eligible (whether enrolled or not) for coverage under any group health benefits plan or employer sponsored health benefit plan? ☐ ☐

   If yes, please state the name(s) of the applicant(s) ____

2. Are any applicant(s) eligible or entitled (whether enrolled or not) for Medicare, Part A or Part B? ☐ ☐

   If entitled, please state the name(s) of the applicant(s) ____

   and the applicant's Medicare Claim Number ____

5. HIPAA ELIGIBILITY INFORMATION (Continued)

	YES	NO
3. Are any applicant(s) eligible (whether enrolled or not) for Medicaid, or any similar state plan under Title XIX of the Social Security Act?	☐	☐
If yes, please state the name of the applicant(s) ____________________		
4. Are any applicant(s) currently covered under any other health benefit plan?	☐	☐
If yes, please state the name of the applicant(s) ____________________		
Provide coverage information in Section 4 (Other Insurance Information), above.		
5. Was the applicant's prior health benefits plan terminated because of nonpayment of premium or subscription charges by the applicant?	☐	☐
If yes, please state the name of the applicant(s) ____________________		
6. Was the applicant's prior health benefits plan terminated for reasons of fraudulent act or intentional misrepresentation by the applicant?	☐	☐
If yes, please state the name of the applicant(s) ____________________		

Federal law requires that a group health plan sponsored by an employer who regularly employs 20 or more employees offer employees and their families the opportunity for a temporary extension of health coverage called Continuation Coverage (or COBRA coverage). This Continuation Coverage is offered for a specific number of months depending on the applicant's situation. The employer or Plan Administrator will be able to tell an applicant(s) how many months of Continuation Coverage is available.

	YES	NO
7. If the applicant(s) were offered this Continuation Coverage, did the applicant(s) refuse this coverage or elect to terminate this coverage before the end of the allowed Continuation Coverage period?	☐	☐
If yes, please state the name of the applicant(s) ____________________		

INSTRUCTIONS:

Applicants REQUIRED to Complete the Health Status Section of the Application:

- Any applicant who has not been covered under any health benefits plan for the past 63 days.
- Any applicant who answered any of the above questions in Section 5 (HIPAA Eligibility Information) with "YES".
- Any applicant who wants to be considered for the Underwritten coverage only or for both the Underwritten coverage (first choice) and the HIPAA coverage (second choice).

Applicants who are NOT Required to Complete the Health Status Section of the Application:

- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 18-months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under individual health insurance coverage, a group health plan, governmental plan, or church plan, or any health benefit plan offered in connection with these plans; and 3) the applicant answered all of the above questions in Section 5 (HIPAA Eligibility Information) with "NO".
- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 12-months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under an individual health insurance policy which was nonrenewed by the health insurance issuer because the health insurance issuer is no longer offering any type of health insurance coverage in the individual market; and 3) the applicant answered all of the above questions in Section 5 (HIPAA Eligibility Information) with "NO".

NOTE: An applicant's prior insurer(s) or health plan(s) are required by federal law to provide a Certificate of Coverage that indicates how many months the applicant has been continuously covered under "creditable coverage", as defined under Federal and State law. Please attach all Certificates of Coverage to this application. Retain a copy for your records.

6. HEALTH EVALUATION

PLEASE COMPLETE SECTIONS A, B, AND C. CHECK EACH ITEM "YES" OR "NO".

	YES	NO
Have you or any family member named in the accompanying application had a physical examination within the past five years?	☐	☐

SECTION 6A — 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	☐	☐
4. Goiter, thyroid condition, diabetes	☐	☐
5. Seizure disorder, central nervous system disorder, multiple sclerosis	☐	☐
6. Substance abuse (drug or alcohol dependency, abuse or addiction)	☐	☐
7. Use of illicit drugs	☐	☐
8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	☐	☐
9. Cataract or other eye condition	☐	☐
10. Tuberculosis, lung condition, asthma, bronchitis	☐	☐
11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	☐	☐
12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)	☐	☐
13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition	☐	☐
14. (Female) Is currently pregnant; expected date of delivery: _____/_____/_____	☐	☐
15. (Male) Prostate condition, reproductive system disorders, infertility	☐	☐
16. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	☐	☐
17. Sexually transmitted diseases	☐	☐
18. Anemia, blood disorders	☐	☐
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?	☐	☐
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?	☐	☐

NOTE: ALL QUESTIONS MUST BE CHECKED "YES" OR "NO" – Or your application will be returned.

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

6. HEALTH EVALUATION (Continued)

SECTION 6B — If you have checked "YES" to any part of SECTION 6A, 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:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL

SECTION 6C — 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

7. 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.

7. CONDITIONS OF ENROLLMENT — Continued

WARNING: It is a fraudulent insurance act for a person knowingly or willfully to make a false or fraudulent statement or representation in or with reference to this application for insurance.

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:______________________