



CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

CareFirst BlueChoice, Inc. Enrollment Form with a Health Questionnaire

(District of Columbia Groups)

HOW TO COMPLETE THIS ENROLLMENT FORM:

- Please type or print clearly with ball point pen.
- Complete all appropriate items, sign and date.
- You MUST** include a Primary Care Physician name and code number for each dependent listed. The Physician Code # is located in the Provider Directory. **Failure to provide this information may delay in-network services.**
- Please return your Form to your Employer.
- Employer must complete if Section VI is answered.** Number of employees in group _____.

I. APPLICANT			
Employer/Group Administrator		Group Number _____	
Effective Date Requested / /		Medical Option _____ Dental Option _____	
Social Security Number		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name		First Name	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 <input type="checkbox"/> Other <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widow(er)	Height /Weight
Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
II. TYPE OF ENROLLMENT		IV. CHANGE TO EXISTING COVERAGE	
CHECK ONE: <input type="checkbox"/> New <input type="checkbox"/> Coverage Change		Dependents affected by adds or deletes must be listed in Section V - Dependent Information	
III. TYPE OF COVERAGE		Identification Number, if different from Social Security Number _____	
CHECK ONE: <input type="checkbox"/> Self-Only Coverage <input type="checkbox"/> Self and Spouse (Two-Party) <input type="checkbox"/> Self and Child (Two-Party) <input type="checkbox"/> Family <input type="checkbox"/> Coverage Complementary to Medicare (Self-Only)		<input type="checkbox"/> ADD dependent(s) listed in Section V	
COVERAGE SELECTED: Check only those options that your employer has elected to offer. <input type="checkbox"/> BlueChoice <input type="checkbox"/> BlueChoice Opt-Out		<input type="checkbox"/> ADD spouse due to marriage on _____ (Date)	
<input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental HMO Opt-Out <input type="checkbox"/> Preferred Dental <input type="checkbox"/> Traditional Dental <input type="checkbox"/> BlueVision Plus		<input type="checkbox"/> ADD child due to adoption on _____ (Date) or appointed legal guardian by court decree dated _____.	
		(Note: Documentation of adoption or court-appointed legal guardianship must be provided.)	
		<input type="checkbox"/> REMOVE dependent(s) listed in Section V due to _____	
		_____ (Reason) _____ (Date)	
		<input type="checkbox"/> CHANGE address to that shown in Section I above	
		<input type="checkbox"/> CHANGE my name from _____ to that shown in Section I	
		<input type="checkbox"/> CHANGE Primary Care Physician to that shown in Section I for applicant and Section V for dependent	

V. DEPENDENT INFORMATION

1 Spouse	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height /Weight
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
2 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height /Weight
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
3 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height /Weight
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
4 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height /Weight
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
5 Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height /Weight
	Name of Primary Care Physician		Physician Code #		Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

COMPLETE ONLY IF DEPENDENT CHILD LISTED ABOVE IS AGE 19 OR OVER

Dependent Name - (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH STUDENT CERTIFICA- TION FORM	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH DISABILITY CERTIFICATION FORM AND SUPPORTING DOCUMENTA- TION
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	

VI. MEDICARE COVERAGE

FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, WILL CAUSE SIGNIFICANT PROCESSING DELAYS.

Check this block if any person listed on this Form is eligible for or receiving benefits under Medicare.

If you checked the block, 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 ____/____/____

Name _____ Reason for entitlement: Age 65 or older Kidney disease Disabled

Medicare Claim No. _____ Eligible for: Part A Eff. Date ____/____/____ Part B Eff. Date ____/____/____

Employee Status: (Check only one box) Actively Employed Retired

VII. PRIOR COVERAGE / OTHER COVERAGE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

Check this block if any person listed on this Form is now or has within the last 31 days been enrolled in health care or catastrophic coverage through a Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization, another insurance carrier or Medicaid. If you have checked the block, please give:

1. Policy Holder's Name _____ Date of Birth _____ / _____ / _____
month day year

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. Services Covered | A. Hospital | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | B. Physician | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | C. Out-of-pocket Major Medical | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | D. Separate Drug Program | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | E. Dental | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | F. Eye or Vision Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | G. Mental Illness | <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. Will this coverage be continued? Yes No
 If so, please provide cancellation date or intended cancellation date _____ / _____ / _____
month day year

Reason for cancellation _____

Is coverage under COBRA? Yes No

VIII. HEALTH QUESTIONNAIRE

CHECK EACH ITEM YES OR NO. PLEASE COMPLETE SECTIONS A, B AND C (If confidentiality is desired, please make arrangements with your Group Administrator.)

SECTION A - CHECK EACH ITEM YES OR NO (If confidentiality is desired, please make arrangements with your Group Administrator.) To the best of your knowledge and belief, has any person named in this Form had within the last 7 years or does such person now have, any of the following?

- | YES | NO | | YES | NO | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | (a) Cancer, tumor or other growth (malignant or benign) | <input type="checkbox"/> | <input type="checkbox"/> | (j) Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition |
| <input type="checkbox"/> | <input type="checkbox"/> | (b) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus Seropositivity (Positive HIV test) | <input type="checkbox"/> | <input type="checkbox"/> | (k) Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke) |
| <input type="checkbox"/> | <input type="checkbox"/> | (c) Kidney stones, kidney or bladder condition, urinary frequency or burning | <input type="checkbox"/> | <input type="checkbox"/> | (l) (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition |
| <input type="checkbox"/> | <input type="checkbox"/> | (d) Goiter, thyroid condition, diabetes | <input type="checkbox"/> | <input type="checkbox"/> | (m) (Female) is currently pregnant; expected date of delivery: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | (e) Seizure disorder, central nervous system disorder, multiple sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | (n) (Male) Prostate condition, reproductive system disorders, infertility |
| <input type="checkbox"/> | <input type="checkbox"/> | (f) Substance abuse (drug or alcohol dependency, abuse or addiction) | <input type="checkbox"/> | <input type="checkbox"/> | (o) Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | (g) Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition | <input type="checkbox"/> | <input type="checkbox"/> | (p) Sexually transmitted diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | (h) Cataract or other eye condition | <input type="checkbox"/> | <input type="checkbox"/> | (q) Anemia, blood disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | (i) Tuberculosis, lung condition, asthma, bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | |

VIII. HEALTH QUESTIONNAIRE (continued)

SECTION B - In addition to the conditions listed in **SECTION A**, to the best of your knowledge and belief, within the past 5 years, has any person named in this Form:

YES NO

- (a) Had a physical examination?
- (b) 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 reason for prescription medication **not** listed in **SECTION A**?
- (c) Had any departure from good health **not** previously mentioned in any of the above questions for which treatment or advice may or may not have been sought?

SECTION C - If you have checked "YES" to any part of **SECTION A** or **SECTION B**, for each block checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgery, and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Patient's First Name	Section & Letter	Diagnosis or Condition	Duration Dates From To	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician's/hospital's name.	Recovery Check only one box
					<input type="checkbox"/> Full <input type="checkbox"/> Partial
					<input type="checkbox"/> Full <input type="checkbox"/> Partial
					<input type="checkbox"/> Full <input type="checkbox"/> Partial

PLEASE READ CAREFULLY - THIS SECTION MUST BE DATED AND SIGNED

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this Form is accepted, coverage will be provided according to the terms and conditions of the contract between CareFirst BlueChoice, Inc. 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 subscription charges to my employer.

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, an insurer 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. 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 enrollment for coverage.

X _____ X _____
Date Signature of Applicant

Redate and Resign below **ONLY** if block is checked.

X _____ X _____
Date Signature of Applicant