

**ENROLLMENT FORM
WITH A HEALTH QUESTIONNAIRE
(District of Columbia Groups)**



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

1 EMPLOYER INFORMATION: To be completed by the employer.

Employer/Group Administrator	Group Number:
Effective Date Requested ___/___/___	Medical: _____ Dental: _____
	Medical Option: _____ Vision: _____

Check all that apply

Employment Status Active Full Time Part Time Retired

2 TYPE OF REQUEST

<input type="checkbox"/> New Subscriber <input type="checkbox"/> Coverage Change <input type="checkbox"/> Add Dependents <input type="checkbox"/> Delete Dependents	Are you enrolling eligible dependents?
<input type="checkbox"/> Any information change (name or address change)	<input type="checkbox"/> Yes <input type="checkbox"/> No

3 SUBSCRIBER INFORMATION

Social Security Number ____-____-____	Subscriber Last Name	First Name	Middle Initial
Date of Birth ___/___/___	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire: ___/___/___	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed Effective Date of Marital Status ___/___/___
Street Address	Apt.	City	County State
Country	Zip	Home Phone () _____ - _____	Work Phone () _____ - _____

4 CHANGE TO EXISTING COVERAGE

Dependents affected by adds or deletes must be listed in Section 5 Dependent Information.

Identification Number, if different from Social Security Number _____

ADD dependent(s) listed in Section 5

ADD spouse due to marriage on _____ (Date)

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. CareFirst BlueCross BlueShield will pay the cost of the documentation required to provide proof of adoption or court-appointed legal guardianship.)

REMOVE dependent(s) listed in Section 5 due to _____ (Reason)
_____ (Date)

CHANGE address to that shown in Section 3 above

CHANGE my name from _____ to that shown in Section 3

5 SUBSCRIBER & DEPENDENT INFORMATION: Please list all persons to be covered.

COVERAGE LEVEL – Please confirm with your employer the details of the benefit options offered by your employer prior to completing this section to avoid delays in processing this Enrollment Form.

COVERAGE LEVELS OF SUBSCRIBER AND DEPENDENTS, IF APPLICABLE

Coverage Level for Medical Option (if applicable and your employer has elected to offer):
 Self Self and Child Self and Spouse Family Coverage Complementary to Medicare (self-only)

Coverage Level for Dental Option (if applicable and your employer has elected to offer):
 Self Self and Child Self and Spouse Family

Coverage Level for BlueVision Plus Option (if applicable and your employer has elected to offer):
 Self Self and Child Self and Spouse Family

SUBSCRIBER INFORMATION

Last	First	MI	Coverage Level	Relationship	Sex	Height	Weight	Date of Birth	Social Security Number
			<input type="checkbox"/> Medical <input type="checkbox"/> Traditional Dental <input type="checkbox"/> Preferred Dental <input type="checkbox"/> BlueVision Plus	Subscriber					

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5 SUBSCRIBER & DEPENDENT INFORMATION (continued)

DEPENDENT INFORMATION: If the subscriber has more than four dependents, please list the additional dependents on a separate Enrollment Form.

Last	First	MI	Coverage Level	Relationship	Sex	Height	Weight	Date of Birth	Social Security Number
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus						
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus						
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus						
			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus						

Is anyone listed above a student or disabled? YES NO
 If the answer is YES, please list the name of the person _____
 If a full-time student, please attach student certification form. If yes, disabled, please attach disability certification form and supporting documentation.

6 MEDICARE INFORMATION: To be completed if applicable.

Are You Eligible for Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: ____ - ____ - ____ - ____	Hosp. Eff. Date (Part A) ____ / ____ / ____	Med. Eff. Date (Part B) ____ / ____ / ____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				
Spouse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: ____ - ____ - ____ - ____	Hosp. Eff. Date (Part A) ____ / ____ / ____	Med. Eff. Date (Part B) ____ / ____ / ____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				
Child/Dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number If Yes: ____ - ____ - ____ - ____	Hosp. Eff. Date (Part A) ____ / ____ / ____	Med. Eff. Date (Part B) ____ / ____ / ____
Reason for Entitlement: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled				

7 OTHER HEALTH INSURANCE INFORMATION

IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

Is any person listed on the enrollment form covered by another health care plan, HMO, or Medicare? Yes No
 If yes, will this coverage be continued? Yes No If no, please provide the cancellation date ____ / ____ / ____

Policyholder's Name	Phone Number of Other Insurer () ____ - ____	Date of Birth ____ / ____ / ____
Name and Address of Insurance Company		
Policy Number	Termination Date ____ / ____ / ____	Effective Date of Policy ____ / ____ / ____
Services Covered: <input type="checkbox"/> Hospital Services <input type="checkbox"/> Physician Services <input type="checkbox"/> Major Medical <input type="checkbox"/> Drug Program <input type="checkbox"/> Dental Services <input type="checkbox"/> Eye/Vision Care Services <input type="checkbox"/> HMO <input type="checkbox"/> Mental Illness Services		
Does this policy cover you? <input type="checkbox"/> Yes <input type="checkbox"/> No Your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No Your children? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list name(s) of children covered _____ Is this coverage under COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason for cancellation _____ _____ Cancellation Date ____ / ____ / ____		

8 HEALTH QUESTIONNAIRE

NOTE: Check with your Group Administrator before you complete Sections A, B, and C. This information may not be required.

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 Enrollment Form had within the last seven years or does such person now have, any of the following?

YES NO

- (a) Cancer, tumor or other growth, (malignant or benign)
- (b) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test)
- (c) Kidney stones, kidney or bladder condition, urinary frequency or burning
- (d) Goiter, thyroid condition, diabetes
- (e) Seizure disorder, central nervous system disorder, multiple sclerosis
- (f) Substance abuse (drug or alcohol dependency, abuse or addiction)
- (g) Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition
- (h) Cataract or other eye condition
- (i) Tuberculosis, lung condition, asthma, bronchitis

YES NO

- (j) Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition
- (k) Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)
- (l) (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition
- (m) (Female) Is currently pregnant; expected date of delivery: ___/___/___
- (n) (Male) Prostate condition, reproductive system disorders, infertility
- (o) Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder
- (p) Sexually transmitted diseases
- (q) Anemia, blood disorders

SECTION B - In addition to the conditions listed in **SECTION A**, to the best of your knowledge and belief, within the past five years, has any person named in this Enrollment 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		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
						<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
						<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
						<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL

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 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 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.

Subscriber's Signature

__/__/__
Date

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