

Application for Group Coverage

(Maryland Groups not subject to Small Group Reform)

HOW TO COMPLETE THIS APPLICATION:

- Please type or print clearly with ball point pen.
- Complete all appropriate items, sign and date.
- Employer must complete if Section VI is answered.**
Number of employees in group _____
- Please return your application to your Employer.

I. APPLICANT						
Last Name		First Name		Initial	Social Security Number	
Residence Address (Number and Street) (City and State)				(Zip Code-9-digit, if known)	Home Phone ()	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widow(er)			
Employed By (Firm Name)		Address		Group Number	Work Phone ()	
Occupation			Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Date Employed / /	
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 Identification Number, if different from Social Security Number _____ <input type="checkbox"/> ADD dependent(s) listed in Section V below <input type="checkbox"/> ADD spouse due to marriage on _____ (Date) <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) due to _____ (Reason) on _____ (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 above			
III. TYPE OF COVERAGE						
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"/> Is coverage complementary to Medicare? If so, complete Section VI, Medicare Coverage.						
V. DEPENDENT INFORMATION						
1	Spouse	Name - (Last) (First) (MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
2	Child	Name - (Last) (First) (MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
3	Child	Name - (Last) (First) (MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
4	Child	Name - (Last) (First) (MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship
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 CERTIFICATION FORM	DISABLED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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	
IF YES, ATTACH DISABILITY CERTIFICATION FORM AND SUPPORTING DOCUMENTATION						

PLEASE COMPLETE REVERSE SIDE

VI. MEDICARE COVERAGE

Check this block if any person listed on this application 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 INSURANCE INFORMATION

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

Check this block if any person listed on this application 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: _____ Date of Birth ____/____/____

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	E. Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Physician Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	F. Eye/Vision Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Major Medical (out-of-pocket expenses)	<input type="checkbox"/> Yes <input type="checkbox"/> No	G. Mental Illness Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Separate Drug Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	H. HMO	<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. Is this coverage under COBRA? Yes No Reason for cancellation: _____

8. To be completed if the natural parents live apart and provide medical coverage for their children. Please indicate relationship to children (natural mother, natural father, step-parent):

PARENT WITH COURT ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES

 Parent's Name / Child's Date of Birth

 Relationship to Child / Child's Name

PARENT WITH CUSTODY OF CHILD(REN)

 Parent's Name / Child's Date of Birth

 Relationship to Child / Child's Name

VIII. PLEASE READ CAREFULLY -- THIS SECTION MUST BE DATED AND SIGNED

IT IS UNDERSTOOD AND AGREED THAT:

- (a) The statements and answers made herein are complete and correct to the best of my knowledge and belief, and are made to cause the issuance of, and to become a part of, the coverage for which I am applying. Should any statement or answers made herein change before the coverage becomes effective I will promptly notify CareFirst BlueCross BlueShield (hereafter "CareFirst").
- (b) Coverage will become effective according to your Group's eligibility guidelines following approval of this application by CareFirst.
- (c) Should any statements or answers contained in this application be untrue (if such statements are fraudulent or material to the acceptance of this application), then the contract may be cancelled by CareFirst, and its obligation shall consist only of the return of any subscription charges actually paid, less the amount of any benefits paid under the coverage.
- (d) The Subscriber shall repay to CareFirst the amount of any payment(s) made in error to the Subscriber on the behalf of the Subscriber or any covered family member as the result of a claim.
- (e) If this application is approved by CareFirst, I authorize any Provider to forward to CareFirst information concerning medical, surgical, psychiatric or psychological services or supplies provided to me or to any of my dependents listed on this application for the purpose of review, investigation or payment of a claim. This authorization is valid for the duration of coverage.
- (f) Unless waived by CareFirst, there is a waiting period which all members must satisfy before benefits are available for certain conditions.
- (g) A copy of this application is available to the Subscriber (or a person authorized to act on his behalf) upon request.

X _____
 Signature of Applicant Date