

The following pages are your DC

BlueCross BlueShield Health Insurance Application
from RxMom.com



Please follow these steps to complete

- 1. Print the Application below
- 2. Fill out the Forms Completely. Please include all details and remember to sign the application.
- 3. **Fax (866)707-9532** or Mail the entire application form to:

BlueCross by RxMom.com
P O Box 488
Laurel, MD 20725

Please **DO NOT** send any payment. If your application is approved
CareFirst BlueCross Blue Shield will bill you directly

You may additionally choose to enroll for the **AUTOMATIC DEBIT PLAN** by completing the
Authorization form (Please Remember to Attach a Voided Check) **MAIL IN ONLY**

PLEASE CALL US AT **(888)490-8782** If you have any questions

IMPORTANT

*Rates subject to change without notice.

-This is an application for an underwritten plan. Underwriting can take between 4-6 weeks (This can be considerably shorter for a healthy applicant with a complete application)

-You do NOT have coverage until your application is accepted by CareFirst BlueCross BlueShield

-Please do NOT cancel any existing coverage during the underwriting process

-If you do not have any coverage you may apply for temporary or Short Term health Insurance at RxMom.com

-Short term Insurance can start as early as tomorrow thus you can use it during the underwriting process.

Individual CareFirst BlueChoice, Inc. BlueChoice-Saver Application



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

OFFICE USE ONLY:

(District of Columbia Residents)

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

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Be sure to select a **Primary Care Physician (PCP) and PCP ID number** for all enrolled applicants.
3. 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.

Please Fax to: (866)707-9532
or Mail to:
BlueCross by RxMom.com
P O Box 488
Laurel, MD 20725

1. APPLICANT INFORMATION (The oldest applicant will be the Subscriber.)

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			
Name of Primary Care Physician (PCP)				PCP ID Number	

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:

CHECK:	PCP/Specialist Copay	Inpatient Hospital	Prescription Drug
<input type="checkbox"/>	\$30/\$40	\$600 per day	\$150 deductible, \$1,500 max on generic drugs

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

DENTAL BENEFITS: Check here if you wish to include benefits for dental services (additional cost). Yes

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:	EBCA	542015926	98D
Sub-Agent/Sub-Agency:	Thomas Musembi		
Writing Agent:			

CareFirst BlueChoice, Inc. 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.)	Medical Center or PCP Name (Include PCP ID #)
Spouse/Partner						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 5						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 BlueChoice-Saver coverage replace your existing policy? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has anyone listed on this application been without health insurance for the past 12 months or longer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?	<input type="checkbox"/>	<input type="checkbox"/>

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) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Kidney stones, kidney or bladder condition, urinary frequency or burning | <input type="checkbox"/> | <input type="checkbox"/> |

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 CareFirst BlueChoice, Inc. (CareFirst BlueChoice).

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 BlueChoice 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 BlueChoice 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 BlueChoice.

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 BlueChoice 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 (oldest applicant).

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: _____

Automatic Debit

Five Good Reasons to Sign Up Now

- **Automatic Debit is convenient and saves you time and money.** You no longer have to write checks and pay for postage.
- **Automatic Debit helps you budget your health insurance premiums.** You can conveniently keep an eye on your budget and statements.
- **Automatic Debit provides excellent record keeping.** Your monthly bank or credit card statement helps keep track of all your premiums.
- **Automatic Debit gives you peace of mind.** There's no need to worry about forgetting to mail your payment or missing a bill.
- **Automatic Debit is absolutely free.** As a valued CareFirst BlueCross BlueShield customer, you can enjoy the convenience of Automatic Debit at no additional cost.

How Do I Sign Up?

If you already have coverage with CareFirst BlueCross BlueShield, simply complete the Automatic Debit authorization form and mail it to us. Just indicate which option you prefer - checking account or credit card. Regardless of the option you choose, your monthly charge will automatically take place on the 25th day of each month prior to your coverage month. For example, you will pay your monthly premium on May 25 for coverage in June. Please be sure to include a blank check marked "Void" along with your authorization form so that we can notify your bank. If you are choosing the credit card option, please remember to send us notification when your card expires.

If you're applying for CareFirst BlueCross BlueShield coverage, attach your Automatic Debit authorization form along with a voided check to your application for medical coverage, and return them together to CareFirst.

Important: It will take four weeks for your Automatic Debit authorization to be processed. Once your application for medical coverage has been processed and approved, you will receive a bill in the mail. When you receive your first bill, you must pay it and send in your payment. It is very important that you pay this bill on time in order to keep your coverage in effect. We will notify you in writing when your monthly Automatic Debit payments will begin. Until that time, please pay any bills you receive.

What Else Do I Need To Know?

If there are any changes to your bank or checking account, please let our Customer Service Representatives know right away so that your Automatic Debit option can continue without interruption. If, for whatever reason, you would like to discontinue Automatic Debit, simply call or write us. Your request will take 2 weeks to process. If your account has insufficient funds available to pay the premium amount due, you will receive a double bill the next time along with a letter advising you that if you have one more non-sufficient funds draft, you will be terminated from the program.

To elect the Automatic Debit monthly payment option, just complete and mail the attached authorization form. You will receive an invoice monthly. You do not need to send a check (except for the first month's premium) unless advised in writing.

Please fill out the Automatic Debit Authorization Form and return it today.

AUTOMATIC DEBIT PLAN AUTHORIZATION FORM

Yes, I'd like to enroll

For office use only

(Please Print)

Date _____

Policyholder Name _____

Address _____

Telephone (____) _____

(Enrolled Members) CareFirst BlueCross BlueShield Group Number _____

(Enrolled Members) CareFirst BlueCross BlueShield Identification Number _____

CHOOSE PREFERRED AUTOMATIC DEBIT OPTION

Checking Account Option

Bank Name _____

Bank Address _____

Account Number _____

Authorized Signature _____

Date _____

Credit Card Option

Type of Credit Card: VISA® MasterCard® Exp. Date _____
MM / YY

Account Number _____

Name on Credit Card _____

Authorized Signature _____

Date _____

Important: Please attach a blank check marked "Void" showing your pre-printed account number.

Failure to provide a copy of your voided check will result in a delay in your Automatic Debit application.

The completed form must be returned to: Collections Unit/Automatic Debit, CareFirst BlueCross BlueShield, 840 First St. NE, Washington, DC 20065

I (We) hereby authorize CareFirst BlueCross BlueShield to initiate entries to either my/our checking or credit card account indicated above and the Financial Institution named above to credit/debit the same to such account.

CareFirst BlueCross BlueShield will complete the debit transaction only if a voided check containing this information is attached. This authority is to remain in full force and effect until the Financial Institution has received notification from either party of its termination in such time and such manner as to afford the Financial Institution reasonable time to act on it. A customer has the right to stop payment of a debit/credit card entry by notification to CareFirst BlueCross BlueShield and the Financial Institution prior to charging the account. After the account has been charged, a customer has the right to have the amount of any erroneous amount immediately credited to the customer's account by the Financial Institution up to 15 days following issuance of statement or 45 days after posting, whichever occurs first.

In case of errors or questions, write to CareFirst BlueCross BlueShield at the following address:

**Collections Unit/Automatic Debit
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065**

By signing below I acknowledge that I have read and understand this authorization.

Policyholder Signature _____

Date _____