

Individual CareFirst BlueChoice, Inc. Health Savings Account (HSA) Application



OFFICE USE ONLY:

(Maryland Residents)

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

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

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 if provided, or mail to CareFirst BlueCross BlueShield, Individual Market Division/ RR-291, 10455 Mill Run Circle, Owings Mills, MD 21117-9685.

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.**

Fast Service Fax Application To:
Fax (866) 707-9532
or Mail To:
RxMom.com Blue Cross Application
7272 Cradlerock Way Suite 100
Columbia MD 21045

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, Street, Apt. #)		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 DESIRED:

Check one:	Deductible	PCP/ Specialist Copay	Out-of-Pocket Max	Prescription Drug (after ded.)
<input type="checkbox"/>	\$1,200 (Individual) / \$2,400 (Family aggregate)	\$30 / \$40	\$2,400 (Individual) / \$4,800 (Family aggregate)	\$5 / \$25 / \$45
<input type="checkbox"/>	\$2,700 (Individual) / \$5,400 (Family aggregate)	\$30 / \$40	\$5,250 (Individual) / \$10,500 (Family aggregate)	\$5 / \$25 / \$45

VISION BENEFITS: Check this box if you wish to include benefits for vision services (additional cost). Yes

IMPORTANT DEDUCTIBLE INFORMATION

Individual Coverage: A Member who has Individual Coverage must satisfy the Individual Deductible.

Individual & Adult, Individual & Child(ren), and Family Coverage: Members who select these types of coverage will have the Deductible amount calculated in the aggregate. There is no Individual Deductible for these types of coverage. The aggregate Family Deductible must be reached before CareFirst BlueChoice pays for any Member with these types of coverage.

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2. COVERAGE SELECTION (Continued)

IMPORTANT OUT-OF-POCKET LIMIT INFORMATION

Individual Coverage: A Member who has Individual Coverage must meet the Individual Out-of-Pocket Limit.

Individual & Adult, Individual & Child(ren), and Family Coverage: Members who select these types of coverage will have the Out-of-Pocket Limit calculated in the aggregate. There is no Individual Out-of-Pocket Limit with these types of coverage. When the Family aggregate Out-of-Pocket Limit is reached by one or more members of the family, no further copayments, coinsurance or deductibles will be required for that calendar year.

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? YES NO

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? YES NO

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 BlueChoice coverage replace your existing policy? YES NO

3. Has anyone listed on this application been without health insurance for the past 12 months or longer? YES NO

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 this application had a physical examination within the past five years? YES NO

5. HEALTH EVALUATION (Continued)

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)
- 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.

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	Medication	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 occur prior to acceptance of this application by CareFirst BlueChoice.

By signing this Application, I hereby authorize CareFirst BlueChoice to disseminate and share non-health questionnaire information contained on this Application with the Health Savings Account (HSA) preferred bank(s) affiliated with CareFirst BlueChoice. I understand that dissemination of information to any such bank is at my direction and with my full understanding. Further that dissemination of information on this Application, excluding health questionnaire information, is necessary in order to effectuate the establishment of a Health Savings Account in my name with the HSA bank. The authorization shall continue until my enrollment with CareFirst BlueChoice terminates or at any time that I provide a written instruction to CareFirst BlueChoice revoking this authorization or if this authorization terminates by operation of law.

If you do not want information on this Application shared with the HSA preferred bank(s) please check here.

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.

An applicant or dependent whose Application is denied by CareFirst BlueChoice due to medical underwriting may not submit a subsequent Application for enrollment within ninety (90) days of the denial.

6. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully (continued)

WARNING: It is a crime to knowingly or willingly 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: _____

For Office Use Only:

Re-sign and re-date below **only** if box is checked.

Signature of Applicant 1:* X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____

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