

# Individual BluePreferred-Saver Application

OFFICE USE ONLY:

(Virginia Residents)



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

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

**INSTRUCTIONS**

- Please fill out all applicable spaces on this application. Print or type all information.
- 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.*

Fax Application to (866)707-9535  
 or  
 Mail Application To:  
**RxMom.com -BlueCross Processing**  
**7272 Cradlerock Way Suite 100**  
**Columbia MD 21046**

**TYPE OF ENROLLMENT (CHECK ONE)**

Underwritten     Underwritten (First choice) or HIPAA (Second choice)  
 HIPAA

**1. APPLICANT INFORMATION**

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		Height	Weight
Home Phone ( )	Work Phone ( )	E-mail Address			

**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		Coverage Level		Out-of-Pocket Limit	
	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)	(In-Network)	(Out-of-Network)
<input type="checkbox"/>	\$2,500	\$5,000	70%	60%	\$5,000	\$10,000
<input type="checkbox"/>	\$5,000	\$10,000	100%	80%	\$5,000	\$12,500
<input type="checkbox"/>	\$10,000	\$12,500	100%	80%	\$10,000	\$15,000

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

FOR BROKER USE ONLY:	<b>Name:</b>	<b>SSN/Tax ID #:</b>	<b>CareFirst-Assigned ID#:</b>
<b>Contracted Broker:</b>	EBCA	54-2015926	98D
<b>Sub-Agent/Sub-Agency:</b>	Thomas Musembi		
<b>Writing Agent:</b>			

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**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.)
Spouse						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 5						<input type="checkbox"/> M <input type="checkbox"/> F		

**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"/>	<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 Blue Shield coverage? .....	<input type="checkbox"/>	<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 CareFirst BluePreferred coverage replace your existing policy? .....	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
If yes, please list name(s): _____			

**5. HIPAA ELIGIBILITY INFORMATION**

		YES	NO
1. Are any applicant(s) eligible (whether enrolled or not) for coverage under any group health benefits plan or employer sponsored health benefit plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please state the name(s) of the applicant(s) _____			
2. Are any applicant(s) eligible or entitled (whether enrolled or not) for Medicare, Part A or Part B?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If entitled, please state the name(s) of the applicant(s) _____			
and the applicant's Medicare Claim Number _____			

## 5. HIPAA ELIGIBILITY INFORMATION (Continued)

3. Are any applicant(s) eligible (whether enrolled or not) for Medicaid, or any similar state plan under Title XIX of the Social Security Act? **YES** **NO**

If yes, please state the name of the applicant(s) \_\_\_\_\_

4. Are any applicant(s) currently covered under any other health benefit plan?

If yes, please state the name of the applicant(s) \_\_\_\_\_

Provide coverage information in Section 4 (Other Insurance Information), above.

5. Was the applicant's prior health benefits plan terminated because of nonpayment of premium or subscription charges by the applicant?

If yes, please state the name of the applicant(s) \_\_\_\_\_

6. Was the applicant's prior health benefits plan terminated for reasons of fraudulent act or intentional misrepresentation by the applicant?

If yes, please state the name of the applicant(s) \_\_\_\_\_

Federal law requires that a group health plan sponsored by an employer who regularly employs 20 or more employees offer employees and their families the opportunity for a temporary extension of health coverage called Continuation Coverage (or COBRA coverage). This Continuation Coverage is offered for a specific number of months depending on the applicant's situation. The employer or Plan Administrator will be able to tell an applicant(s) how many months of Continuation Coverage is available.

7. If the applicant(s) were offered this Continuation Coverage, did the applicant(s) refuse this coverage or elect to terminate this coverage before the end of the allowed Continuation Coverage period?

If yes, please state the name of the applicant(s) \_\_\_\_\_

### **INSTRUCTIONS:**

#### **Applicants REQUIRED to Complete the Health Status Section of the Application:**

- Any applicant who has not been covered under any health benefits plan for the past 63 days.
- Any applicant who answered any of the above questions in Section 5 (HIPAA Eligibility Information) with "YES".
- Any applicant who wants to be considered for the Underwritten coverage only or for both the Underwritten coverage (first choice) and the HIPAA coverage (second choice).

#### **Applicants who are NOT Required to Complete the Health Status Section of the Application:**

- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 18-months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under individual health insurance coverage, a group health plan, governmental plan, or church plan, or any health benefit plan offered in connection with these plans; and 3) the applicant answered all of the above questions in Section 5 (HIPAA Eligibility Information) with "NO".
- Any applicant who submits a Certificate of Coverage(s) that states: 1) that the applicant has a total of 12-months or more of continuous creditable coverage; 2) whose most recent creditable coverage was under an individual health insurance policy which was nonrenewed by the health insurance issuer because the health insurance issuer is no longer offering any type of health insurance coverage in the individual market; and 3) the applicant answered all of the above questions in Section 5 (HIPAA Eligibility Information) with "NO".

**NOTE:** An applicant's prior insurer(s) or health plan(s) are required by federal law to provide a Certificate of Coverage that indicates how many months the applicant has been continuously covered under "creditable coverage", as defined under Federal and State law. Please attach all Certificates of Coverage to this application. Retain a copy for your records.

## 6. HEALTH EVALUATION

**PLEASE COMPLETE SECTIONS A, B, AND C. CHECK EACH ITEM "YES" OR "NO".**

Have you or any family member named in the accompanying application had a physical examination within the past five years? .....  **YES**  **NO**

**SECTION 6A — 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:**

- |  | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|
| 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"/> |
| 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.**

**NOTE: FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN VOIDING OF MEMBERSHIP AND DENIAL OF BENEFITS.**

## 6. HEALTH EVALUATION (Continued)

**SECTION 6B — If you have checked “YES” to any part of SECTION 6A, 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

**SECTION 6C — 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

## 7. 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 Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst).

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 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 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.

**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.**

**7. CONDITIONS OF ENROLLMENT — Continued**

**WARNING:** It is a fraudulent insurance act for a person knowingly or willfully to make a false or fraudulent statement or representation in or with reference to this application for insurance.

**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.

**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: \_\_\_\_\_