Individual Select Dental Application

(District of Columbia and Virginia Residents)

CareFirst BlueChoice, Inc.

CareFirst BlueCross BlueShield
Group Hospitalization and Medical Services, Inc.

840 First Street, NE, Washington, DC 20065

OFFICE USE ONLY:	
ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. 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.***

Questions? Call Tom at (888)490-8782
or email: insurance@rxmom.com http://www.RxMom.com

Individual Select **DENTAL HMO**	Individual Select **PREFERRED (PPO)**
Please make checks payable to **CAREFIRST BLUECHOICE** and mail to: CF BLUECHOICE DENTAL P O Box 79810 Baltimore,MD 21279-0810	Please make checks payable to **CareFirst Blue Cross BlueShield** and mail to: CF BlueCross BlueShield P O Box 79810 Baltimore, MD 21279-0810

SELECT YOUR PLAN (Check one)

☐ Individual Select DHMO CareFirst BlueChoice, Inc.

☐ Individual Select Preferred Group Hospitalization and Medical Services, Inc.

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, Apt. #) | City and State | Zip Code (9-digit, if known)

Date of Birth	Sex	Marital Status	Plan Type
/ /	☐ Male ☐ Female	☐ Single ☐ Married/Partner	☐ Annual ☐ Semi-Annual

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

2. COVERAGE SELECTION FOR **DENTAL HMO**: (Check one)

☐ **Individual** - Provides coverage for one person
☐ **Individual & Child** - Provides coverage for an individual and eligible dependent (if you have more than one child, you must select Family coverage)
☐ **Individual & Adult** - Provides coverage for two eligible adults
☐ **Family** - Provides coverage for up to two eligible adults and eligible dependent(s)

COVERAGE SELECTION FOR **PREFERRED**: (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)

3. ENROLLING FAMILY MEMBER(S) – **Complete only if you select Individual & Child(ren), Individual & Adult or Family Coverage**

(Dental HMO Plan must have a dental code. Each person can select their own dentist.)

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	Dental Office Code (DHMO Plan only)
Member						☐M ☐F	
Spouse/Partner						☐M ☐F	
Dependent 1						☐M ☐F	
Dependent 2						☐M ☐F	
Dependent 3						☐M ☐F	
Dependent 4						☐M ☐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

Is anyone listed on this application covered by other dental insurance, including other Blue Cross and Blue Shield coverage? ☐ ☐

If yes, please provide the following:

Name of family member(s)_____ Insurance Company_____

Policy Number and Type_____ Effective Date _____

5. 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.

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.

Premium payment options are available on an annual and a semi-annual basis. Those members who elect the semi-annual payment option will be subject to a five dollar ($5) surcharge per payment, which equates to ten dollars annually.

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.

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, Inc., or CareFirst BlueCross BlueShield may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signature of Applicant: X_____ Date:_____

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 Signature: X_____ Date:_____

If you have selected Individual Select **DENTAL HMO**	If you have selected Individual Select **PREFERRED**
Please make checks payable to CAREFIRST BLUECHOICE, INC. and mail to: P.O. Box 79810 Baltimore, MD 21279-0810	**Please make checks payable to CAREFIRST BLUECROSS BLUESHIELD and mail to:** P.O. Box 79810 Baltimore, MD 21279-0810

FOR INTERNAL USE ONLY:

Agency Name RxMom.com Insurance Service Agent Thomas Musembi AGENT #20200			
Agency Address (Number and Street, Apt.#) 4800 Hampden Ln Suite 200		(City and State) Bethesda MD	Zip Code (9-digit, if known) 20814
Telephone Number (888) 490-8782	Fax Number (866) 707-9532	E-mail Address insurance@rxmom.com	
Annual Premium			

CareFirst BlueChoice

CareFirst BlueCross BlueShield

Individual Dental Rates - District of Columbia and Virginia

For Anthem BlueCross Blue Shield Virginia Dental please visit http://www.AnthemVirginiaQuote.com

Individual Select Preferred Dental

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application
Individual	$151.44
Individual & Child(ren)	$280.20
Individual & Adult	$302.88
Family	$424.08

Coverage Type	Semi-Annual Rate Second Payment Due by the 1st of the fifth month from the effective date of coverage	
	1ST PAYMENT	2ND PAYMENT
Individual	$80.72	$80.72
Individual & Child(ren)	$145.10	$145.10
Individual & Adult	$156.44	$156.44
Family	$217.04	$217.04

Please note that when selecting the semi-annual payment, a $5.00 administration fee is already included into each payment. You pay an additional $10/year when you select the semi-annual payment option. The first payment (of the semi-annual rate) is due with the enrollment application. The second payment is due by the 1st of the fifth month from the effective date of coverage.

Individual Select Dental HMO

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application
Individual	$120.00
Individual & Child	$204.00
Individual & Adult	$240.00
Family	$360.00

Coverage Type	Semi-Annual Rate Second Payment Due by the 1st of the fifth month from the effective date of coverage	
	1ST PAYMENT	2ND PAYMENT
Individual	$65.00	$65.00
Individual & Child	$107.00	$107.00
Individual & Adult	$125.00	$125.00
Family	$185.00	$185.00

Please note that when selecting the semi-annual payment, a $5.00 administration fee is already included into each payment. You pay an additional $10/year when you select the semi-annual payment option. The first payment (of the semi-annual rate) is due with the enrollment application. The second payment is due by the 1st of the fifth month from the effective date of coverage.

CareFirst BlueCross Blue Shield Dental Coverage is only available to Virginians residing in the city of Fairfax, the town of Vienna Lorton, Occoquan, Newington, Burke, The City of Fairfax, Annandale, Vienna, Dunn Lorning, Lake Barcroft, North Springfield, Springfield, Lincolnia, Franconia, Fort Belvoir, Huntley Meadows, Fort Hunt, Rose Hill, Bailey's Crossroads, Alexandria, Arlington, McLean, Hooes Road Park, South run, Ox Rd, Groveton, Lee District, Old Town Alexandria, Langley, Arlington Cemetary, Del Ray, Jamestown Park, Glebe Road, Clarendon, Fort Myer, Crystal City, Pentagon City, and the area east of State Route 123, if you do not reside in this area please get dental insurance quotes by visiting http://www.AnthemVirginiaQuote.com

CUT7493-2N (10/08)