Individual Select Preferred Dental Application

(Maryland Residents)

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

CareFirst BlueCross BlueShield

Group Hospitalization and Medical Services, 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. 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 Make Check Payable to CAREFIRST BLUECROSS BLUESHIELD and mail to:

CAREFIRST BLUECROSS BLUESHIELD
P.O. Box 79810
Baltimore, MD 21279-0810

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

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)

Business 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: (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 up to 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

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX
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 applicaton 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 semiannual basis. Those members who elect the semiannual 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: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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:_____

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.#)	(City and State)		Zip Code (9-digit, if known)
4800 Hampden Ln Suite 200	Bethesda MD		20814
Telephone Number	Fax Number	E-mail Address	
(888) 490-8782	(866) 707-9532	insurance@rxmom.com	
Annual Premium			

CareFirst BlueCross BlueShield

Individual Select Preferred Dental Rates
Maryland

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application
Individual	$151.80
Individual & Child(ren)	$280.80
Individual & Adult	$349.20
Family	$425.04

Coverage Type	Semi-Annual Rate Second Payment Due by the first of the seventh month from the effective date of coverage	
	1ST PAYMENT	2ND PAYMENT
Individual	$80.90	$80.90
Individual & Child(ren)	$145.40	$145.40
Individual & Adult	$179.60	$179.60
Family	$217.52	$217.52

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 first of the seventh month from the effective date of coverage.

CUT7491-2N (11/09)