# Individual Select Preferred Dental Application

Virginia

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 all information.
2. Sign and return this application, with exact payment amount, in the postage-paid return envelope or, to **P.O. Box 79810 Baltimore MD 21298-8159**

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If payment amount is incorrect, the application will be returned.***

## 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) |
|---|---|---|
| | | |

| Date of Birth / / | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Domestic Partner | Payment Option ☐ Annual ☐ Semi-annual |
|---|---|---|---|
| | | | |

| Home Phone ( ) | Work/Cell 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)

A "Child" means your eligible child up to age 26. Eligibility requirements are defined in your contract.

An "Adult" means the Spouse or Domestic Partner of the Subscriber who satisfies the eligibility requirements defined in your contract.

## 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 |
|---|---|---|---|---|---|---|
| Spouse | | | | | | ☐M ☐F |
| Domestic Partner | | | | | | ☐M ☐F |
| Dependent 1 | | | | | | ☐M ☐F |
| Dependent 2 | | | | | | ☐M ☐F |
| Dependent 3 | | | | | | ☐M ☐F |

## 4. 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 an additional five dollar ($5) surcharge per payment, which equals to ten dollars ($10) 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 toll-free at (888) 833-8464 before signing this application.

**WARNING: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED VIRGINIA STATE LAW.**

The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

**Signature of Applicant: X** _____ Date: _____

**Signature of Dependent: 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: _____

**Signature of Agent: X** _____ Date _____

## Please make checks payable to:

**CAREFIRST BLUECROSS BLUESHIELD**
**and mail to:**
**Dental Processing Center**
P.O. Box 79810
Baltimore, MD 21298-8159

## AGENTS MUST COMPLETE THIS SECTION

| Agency Name | | | |
|---|---|---|---|
| Thomas Musembi Agent #20200 | | | |
| Agency Address: Number and Street, Apt.# | | City and State | Zip Code (9-digit, if known) |
| RxMom.com Insurance 4800Hampden Ln Suite 200 Bethesda MD | | | 20814 |
| Telephone Number | Fax Number | E-mail Address | |
| ( 888 )490-8782 | ( 866 ) 204-8857 | insurance@rxmom.com | |
| Annual or Semi-annual Premium | | | |