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

The CareFirst BlueCross BlueShield family of health care plans.

Enrollment Form
(Virginia Small Groups)
(Point-of-Service Qualified Health Plan offered on the Virginia Health Benefits Exchange)

This form is used for dually offered products with in-network benefits provided by CareFirst BlueChoice, Inc., and out-of-network benefits provided by CareFirst BlueCross BlueShield

HOW TO COMPLETE THIS FORM:

1. Please type or print clearly with pen.
2. Complete all appropriate items, sign and date.
3. Please return this form to your employer.
4. **Employer must complete if Section VII is answered** – Number of employees in group: _____.

I. EMPLOYER INFORMATION – To be completed by the employer

Employer / Group Administrator	Date of Hire / /	Group Number

II. ENROLLEE

Social Security Number	Date of Birth / /	Sex ☐ Male ☐ Female

Last Name	First Name	Middle Initial

Occupation	Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired

Residence Address *(Number and Street)*	*(City and State)*	*(Zip Code – 9-digit, if known)*

Home Phone ( )	Work Phone ( )	Marital Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Other ☐ Separated ☐ Divorced

Tobacco Usage*
☐ Yes ☐ No
**Tobacco usage means use of tobacco, including cigarettes, on average four or more times per week within no longer than the past 6 months.*

III. TYPE OF ENROLLMENT

CHECK ONE: ☐ New ☐ Coverage Change

IV. PLAN

☐ BlueChoice Advantage 90%/70%

V. CHANGE TO EXISTING ENROLLMENT

Dependents affected by additions or deletions must be listed in Section VI - Dependent Information.

Identification Number, if different from Social Security Number: _____

- ☐ ADD dependent(s) listed in Section VI
- ☐ ADD spouse due to marriage on _____ (Date)
- ☐ ADD domestic partner on _____ (Date)
- ☐ ADD child due to adoption on _____ (Date) or appointed legal guardian by court decree dated _____

  (Note: Documentation of adoption or court-appointed legal guardianship must be provided)
- ☐ REMOVE dependent(s) listed in Section VI due to _____ (Reason) on _____ (Date)
- ☐ CHANGE address to that shown in Section II
- ☐ CHANGE my name from _____ to that shown in Section II
- ☐ CHANGE Primary Care Physician to that shown in Section II for enrollee or Section VI for dependent(s)

VI. DEPENDENT INFORMATION

1	**Spouse**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	Tobacco Usage* ☐ Yes ☐ No
2	**Domestic Partner**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	Tobacco Usage* ☐ Yes ☐ No
3	**Child**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	Tobacco Usage* ☐ Yes ☐ No
4	**Child**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	Tobacco Usage* ☐ Yes ☐ No
5	**Child**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	Tobacco Usage* ☐ Yes ☐ No
6	**Child**	Name – (Last, First, MI)		Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	Tobacco Usage* ☐ Yes ☐ No

VII. MEDICARE COVERAGE

FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

☐ Check this box if any person listed on this form is eligible for or receiving benefits under Medicare.
If you checked the box, please give:

Name _____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No. _____ Eligible for: ☐ Part A Eff. Date ___ /___ /___ ☐ Part B Eff. Date ___ /___ /___

EMPLOYMENT STATUS (CHECK ONLY ONE BOX): ☐ Actively Employed ☐ Retired

Name _____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No. _____ Eligible for: ☐ Part A Eff. Date ___ /___ /___ ☐ Part B Eff. Date __ /___ /___

EMPLOYMENT STATUS (CHECK ONLY ONE BOX): ☐ Actively Employed ☐ Retired

VIII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

☐ Check this box if any person listed on this form is now or has been enrolled within the last 31 days in health care or catastrophic coverage through a Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization, another insurance carrier, or Medicaid. Is this coverage currently in effect? ☐ Yes ☐ No

If Yes, will this coverage be continued? ☐ Yes ☐ No If No, please provide cancellation date _____ /_____ /_____

1. Policy Holder's Name and Social Security Number _____
   Sex ☐ M ☐ F Date of Birth____/_____/_____
2. Name and Location of Insurance Company _____
   _____
3. Policy Number _____ Policy Covers: ☐ Policy Holder Only ☐ Two-Persons ☐ Family
4. Effective Date of Policy _____ /_____ /_____
   month day year
5. Service(s) Covered:

A. Hospital Services	☐ Yes ☐ No	E. Dental	☐ Yes ☐ No
B. Physician Services	☐ Yes ☐ No	F. Eye/Vision Care Services	☐ Yes ☐ No
C. Major Medical (out-of-pocket expenses)	☐ Yes ☐ No	G. Mental Illness Services	☐ Yes ☐ No
D. Separate Drug Program	☐ Yes ☐ No	H. HMO	☐ Yes ☐ No

6. Is coverage through an employer or other group? ☐ Yes ☐ No
   If Yes, name of employer or other group
   _____
7. Is this coverage under COBRA? ☐ Yes ☐ No
8. To be completed if the parents live apart and provide medical coverage for their child(ren):
   Please indicate relationship to child(ren).

PARENT WITH COURT-ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES

_____
Parent's Name / Relationship

_____
Child's Name / Date of Birth

PARENT WITH CUSTODY OF CHILD(REN)

_____
Parent's Name / Relationship

_____
Child's Name / Date of Birth

IX. PLEASE READ CAREFULLY – THIS SECTION MUST BE DATED AND SIGNED

I hereby enroll, on behalf of myself and each dependent listed above, for the coverage indicated. I understand that this is a dually offered product with in-network benefits provided by CareFirst BlueChoice, Inc., and out-of-network benefits provided by CareFirst BlueCross BlueShield. Coverage will be provided according to the terms and conditions of the contract between CareFirst BlueChoice, Inc., CareFirst BlueCross BlueShield, and my employer. I agree to be bound by that contract. If subscription charges are required by my employer, I agree to pay current and future charges to my employer.

CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield may rescind or void my coverage only if (1) I have performed an act, practice, or omission that constitutes fraud; or (2) I have made an intentional misrepresentation of material fact. CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield will provide 30-days advance written notice of any rescission of coverage and refund any paid premiums to the group.

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.

I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date.

This information is subject to verification. Failure to complete any section may delay the processing of your form and/or claims payment.

_____

Enrollee Signature Date

X. CONSENT TO RECEIVE ELECTRONIC NOTICES

CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield want to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield health care coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield health care coverage include, but are not limited to:

- Explanation of Benefits alerts
- Notice of HIPAA Privacy Practices
- Reminders
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note, you may change your email, cell phone and consent information anytime by logging into www.carefirst.com/myaccount or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

I understand that to receive notices through text messaging:

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery, by:

- ☐ Email only
- ☐ Cell phone text messaging only
- ☐ Email and cell phone text messaging

By signing below, I hereby agree to electronic delivery of notices.

Member Name	Signature	Email Address	Cell Phone Number

By signing below, my spouse/partner and any other dependents covered by CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield individually agree to electronic delivery of notices.

Spouse/Partner/ Dependent Name	Signature	Email Address	Cell Phone Number

CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield will not sell your email address or cell phone number to any third party and we do not share them with third parties except for CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield vendors that perform functions on our behalf or to comply with the law.