CareFirst MedPlus

Household Discount Request Form

This is not an application for insurance.

Thank you for your interest in the CareFirst MedPlus plan household discount program. In order to be eligible for this program, two enrollees (per household) are required. Please mail this form back to the address listed below.

**Required information*—Give careful attention to all required fields on this form. Accurate and complete information is necessary before your discount request can be processed. If incomplete, your discount will not be applied.

FOR INTERNAL USE ONLY	IEA Number	Date Form Triggered MONTH / DAY / YEAR

APPLICANT A INFORMATION *(CareFirst MedPlus member initiating discount program request)*			
*Last	*First		MI
*Residence Address (Number and Street, Apt #)			
*City	County	*State	*Zip Code (9-digit, if known)
*Subscriber ID Number	*Group Number	*Date of Birth MONTH / DAY / YEAR	
☐ Check box to confirm your address is the same as the CareFirst MedPlus member listed below.			

REQUIRED SIGNATURE AND DATE	
*Subscriber's Signature	*Date MONTH / DAY / YEAR

APPLICANT B INFORMATION *(A second CareFirst MedPlus member is required to be eligible for the CareFirst MedPlus discount program)*		
*Last	*First	MI
*Subscriber ID	Group Number	*Date of Birth MONTH / DAY / YEAR

REQUIRED SIGNATURE AND DATE	
*Subscriber's Signature	*Date MONTH / DAY / YEAR

Please mail this form to:

Mail Administrator
P.O. Box 14651
Lexington, KY 40512

Fax: **410-505-2901** or **800-305-1351**

www.carefirst.com