Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
and
CareFirst BlueChoice, Inc. (CareFirst BlueChoice)
840 First Street, NE
Washington, DC 20065
202-479-8000

Independent licensees of the Blue Cross and Blue Shield Association

The insurer(s) identified above is (are) responsible for the obligations in this Selection Form.
Selection of one or both of the above is required

Check the appropriate box(es) corresponding with one or both companies for which application is being sought:

☐ CareFirst BlueCross BlueShield (CareFirst)

OR

☐ CareFirst BlueChoice, Inc. (CareFirst BlueChoice)

Selection Form

Select one of the following by checking the appropriate box:

☐ Continuation of Group Coverage for Those Groups Not Eligible for COBRA

OR

☐ Continuation of Group Coverage under USERRA

Continuation of Group Coverage for Those Groups Not Eligible for COBRA

This selection form is for continued group coverage in accordance with Washington DC statute and the Department of Insurance, Securities, and Banking regulations. These regulations enable a member of the group or a family member to continue group coverage (including dental, drug or vision coverage) for up to 3 months after the member ceases to be an eligible employee of the group, as long as the member meets certain requirements. A member who elects to continue coverage shall submit to the group the amount required to continue coverage no later than 45 days after the date that coverage would have otherwise terminated. If a member wishes to continue coverage beyond this period, he or she may apply directly to the District of Columbia's Health Insurance Marketplace through www.DCHealthLink.com for CareFirst and/or CareFirst BlueChoice coverage that is compliant with the new guidelines of the Affordable Care Act (ACA), or health care reform, within 31 days after continued group coverage ends. Neither CareFirst, CareFirst BlueChoice, nor their representatives act as an administrator for continuation of group coverage.

An individual must meet the requirements to qualify for continuation coverage. Different requirements apply to each event that result in loss of group membership, and in certain circumstances, continuation coverage is offered to spouses and dependent children of the qualifying individual.

Continuation of Group Coverage under USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers, and insurers, from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If an eligible employee leaves his or her job to perform military service, the eligible employee has the right to elect to continue their group coverage including any dependents for up to 24 months while in the military. Even if continuation of coverage was not elected during the eligible employee's military service, the eligible employee has the right to be reinstated in their group coverage when re-employed, without any waiting periods or preexisting condition exclusions except for service connected illnesses or injuries. If an eligible employee has any questions regarding USERRA, the eligible employee should contact the plan administrator. The plan administrator determines eligible employees and provides that information to CareFirst.

This form is for data collection purposes only. The above description of continuation of coverage procedures is general in nature.

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 may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Name of Participant(s):_____

_____

Identification Number: _____

Social Security Number: _____

Participant's Address: _____

Home Telephone Number: ( )_____ Work Telephone Number: ( )_____

Group Name: _____ Group Number: _____

Participant's Statement

I understand and agree that in the event I cease to be eligible for continuation of group coverage for any of the reasons below, I must notify my former employer immediately.

1. I have established residence and work outside of the CareFirst BlueChoice Service Area (for those CareFirst BlueChoice products with a residency requirement within the Service Area).
2. I have become eligible for Medicare.

Signature of Participant and Date _____

To Be Completed By the Plan Administrator

1. Date of termination of participant's employment: _____

2. $ _____ is the amount I will collect and remit each month for the continuation of group coverage for this participant.

Signature of Plan Administrator and Date

_____

Please return this Form to:

CareFirst BlueCross BlueShield / CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
Attention: Account Implementation Department
Mailstop DC06-04