Individual Application

2018 Health Insurance Enrollment

Maryland Residents

CareFirst of Maryland, Inc. • 10455 Mill Run Circle, Owings Mills, MD 21117
Group Hospitalization and Medical Services, Inc. • CareFirst BlueChoice, 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 if provided, or mail to:
   Mailroom Administrator
   P.O. Box 14651, Lexington, KY 40512

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 your coverage will be delayed.***

Are you applying for new coverage or are you making changes to a current policy? Check one box.
☐ New coverage ☐ Making changes

1. PRIMARY APPLICANT INFORMATION (The primary applicant will be the Head of Household)

Last Name		First Name	Initial	Social Security #		
Residence Address: (Number and Street, Apt #)		City	State	Zip Code (9-digit, if known)		
Billing Address, if different: (Number and Street, Apt #)		City	State	Zip Code (9-digit, if known)		
Residence County	Date of Birth / /	Sex ☐ Male ☐ Female	Marital Status ☐ Single	☐ Married	☐ Domestic Partner	
Home Phone ( )		Work/Cell Phone ( )				

2. ENROLLING FAMILY MEMBER(S) (Complete only if you are enrolling a Spouse, Partner or Dependent(s) to your plan)

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex
Spouse							☐ M ☐ F
Domestic Partner							☐ M ☐ F
Dependent 1							☐ M ☐ F
Dependent 2							☐ M ☐ F
Dependent 3							☐ M ☐ F
Dependent 4							☐ M ☐ F
Dependent 5							☐ M ☐ F
Dependent 6							☐ M ☐ F
Dependent 7							☐ M ☐ F
Dependent 8							☐ M ☐ F

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.
CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

3. PLAN SELECTION (Check one)

	Plan Name	Deductible In-Network	Deductible Out-of-Network
If you are applying for one of the following **Health Maintenance Organization (HMO)** plans underwritten by CareFirst BlueChoice, Inc., **please check here** ☐			
☐	BlueChoice HMO Young Adult $7,350	Individual: $7,350/Family: $14,700	N/A
BlueChoice Young Adult is only available for individuals under age 30. Some exceptions may apply.			
☐	BlueChoice HMO HSA Bronze $6,550	Individual: $6,550/Family: $13,100	N/A
☐	BlueChoice HMO Silver $3,500	Individual: $3,500/Family: $7,000	N/A
☐	HealthyBlue HMO Gold $1,000	Individual: $1,000/Family: $2,000	N/A
If you are applying for one of the following **Preferred Provider Organization (PPO)** plans, benefits are either underwritten by: Group Hospitalization and Medical Services, Inc. (for residents of Montgomery or Prince George's Counties), **please check here** ☐; or CareFirst of Maryland, Inc. (for residents of Baltimore City or any other county in the state of Maryland, **excluding Montgomery or Prince George's Counties**), **please check here** ☐			
☐	BluePreferred PPO HSA Bronze $6,550	Individual: $6,550/Family: $13,100	Individual: $13,100/Family: $26,200
☐	BluePreferred PPO Silver $3,500	Individual: $3,500/Family: $7,000	Individual: $7,000/Family: $14,000
☐	HealthyBlue PPO Gold $1,000	Individual: $1,000/Family: $2,000	Individual: $2,000/Family: $4,000

Important Deductible Information:

For all plans: Single party applications: the Individual Deductible must be met before full benefits will begin. Multi-party applications: if one member on the policy meets the Individual Deductible, full benefits will begin for that member. That member will not be able to contribute more than the Individual Deductible amount towards the Family Deductible. Once the Family Deductible has been met, full benefits will be available to all members on the policy.

Please Note: Coverage will begin immediately for preventive benefits as they are not subject to a deductible. Other benefits, as specified in the member contract, also may be covered without having to meet a deductible first. In-network and out-of-network (if applicable) deductible expenses will not be applied to each other.

4. PRIMARY CARE PHYSICIAN INFORMATION

If you selected a BlueChoice or HealthyBlue HMO plan in Section 3, please select a Primary Care Physician from the CareFirst BlueChoice Directory available at **www.carefirst.com/doctor**. Indicate the PCP ID number for all enrolling applicants below:

Applicant Name	PCP ID

Spouse/Domestic Partner	PCP ID

Eligible Dependent Name(s)	PCP ID

5. COORDINATION OF BENEFITS

THE PURPOSE OF THIS SECTION IS TO COORDINATE BENEFITS APPROPRIATELY WITH OTHER CARRIERS. IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION MAY CAUSE DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

1. Is anyone listed on this application enrolled in, covered by or eligible for Medicare? ☐ Yes ☐ No

   If yes, please provide the following:

Name of family member(s)	Medicare Number	Effective Date

2. Is anyone listed on this application covered by other health insurance, including other Blue Cross and Blue Shield coverage? ☐ Yes ☐ No

   If yes, please provide the following:

Name of family member(s)	Insurance Company	Policy Number and Type	Effective Date

3. Will your new CareFirst policy be replacing your existing policy? Please note a "Yes" response to this question is not sufficient as notification of policy termination. ☐ Yes ☐ No

6. LIMITED OPEN ENROLLMENT ELIGIBILITY

Do you qualify for a Limited Open Enrollment Period based on one of the triggering events listed below? If YES, please select the triggering event to determine your eligibility. You will be required to provide documentation as proof of your triggering event. If NO, please skip to Section 7.	☐ Yes ☐ No
1. Within the last 60 days, have you married, or entered a domestic partnership? Had a birth, adoption, or been granted court-appointed testamentary, child support order, or other court order of a child or qualified dependent? Had a child placed with you as a foster child by an accredited foster child agency? (Note: The foster child is not eligible for coverage.)	☐ Yes ☐ No
2. Within the last 60 days:	
Have you experienced an error in enrollment by the Maryland Health Connection or by the Department of Health and Human Services?	☐ Yes ☐ No
Were you enrolled in a qualified health plan in which the plan substantially violated a material provision of its contract?	☐ Yes ☐ No
Have you or your dependents become newly eligible or ineligible for subsidies?	☐ Yes ☐ No
Have you lost a dependent, or are no longer considered a dependent, due to a divorce, legal separation, or death?	☐ Yes ☐ No
Have you been released from a prison term resulting from a criminal conviction?	☐ Yes ☐ No
3. Were you covered under a non-calendar year group health plan or individual health insurance policy and are you within 60 days prior to or within 60 days after your policy renewal date?	☐ Yes ☐ No
4. In the next 60 days or within the last 60 days: Will your coverage through an employer-sponsored or has your coverage through an employer-sponsored plan been: discontinued, no longer provide minimum value (plan covers less than 60% actuarial value), or is unaffordable (employee contribution to plan premium of self-only coverage exceeds 9.5% of employee's household income)?	☐ Yes ☐ No
5. Within the last 60 days have you terminated employment and refused COBRA coverage or have you completed the full term of your COBRA coverage?	☐ Yes ☐ No
6. In the next 60 days or within the last 60 days: Will you or have you lost minimum essential coverage (excluding failure to pay premiums and rescissions) or your state-sponsored pregnancy or medically needy coverage through Medicaid?	☐ Yes ☐ No
7. Have you experienced an error in enrollment or subsidy eligibility due to the misconduct of a non-Exchange entity? Misconduct includes failure to comply with applicable standards under state or federal law.	☐ Yes ☐ No
8. In the next 60 days or within the last 60 days, will you or have you gained access to a new Qualified Health Plan as a result of a permanent move to or within Maryland, and for one or more days during the 60 days proceeding the move, you either: had other minimum essential coverage or you were residing in a foreign country or in a United States territory?	☐ Yes ☐ No
9. Within the past 60 days, have you been the victim of domestic abuse or spousal abandonment and you are currently enrolled in other minimum essential coverage through the perpetrator of the abuse or abandonment?	☐ Yes ☐ No
10. Did you apply for Qualified Health Plan coverage through the Maryland Health Connection during the annual open enrollment period or due to a qualifying life event and were told that you potentially qualified for Medicaid or CHIP coverage, but were later determined ineligible for Medicaid or CHIP coverage after your applicable Qualified Health Plan enrollment period had ended? Or did you apply for Medicaid or CHIP coverage through a state agency during the annual Qualified Health Plan open enrollment period but were later determined ineligible for Medicaid or CHIP coverage after the Qualified Health Plan open enrollment period had ended?	☐ Yes ☐ No

7. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) 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 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 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: This consent for electronic communications applies to the Primary Applicant only. Spouse/ Domestic Partners and dependents 18 years of age and older can consent to electronic communications through **www.carefirst.com/myaccount**. Members can also change email 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.

Primary Applicant Name	Email Address	Cell Phone Number
	Alternate Email Address	Alternate Cell Phone Number

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

Signature: X

CareFirst will not sell your email or phone number to any third party and will not share it with third parties except for CareFirst business associates that perform functions on CareFirst's behalf or to comply with the law.

8. CONDITIONS OF ENROLLMENT (Please read this section carefully)

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application will be provided to the Primary Applicant.

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. CareFirst will provide 30-days advance written notice of any rescission of coverage if it is determined that the Primary Applicant performed an act, practice, or omission that constitutes fraud or made an intentional misrepresentation of material fact. CareFirst will refund any premiums to the Primary Applicant. The Member is responsible for repayment of any claim payment made by CareFirst on the Member's behalf.

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 at 800-544-8703 before signing this application.

WARNING: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR 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 Primary Applicant: X	Date
Signature of Applicant 2: X (Spouse or Domestic Partner)	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's Signature: X	Date

9. RACE, ETHNICITY, LANGUAGE (This information is voluntary)

As required by Maryland law, CareFirst is asking its members to voluntarily provide their race, ethnicity and language attributes. The information provided, while voluntary, will assist the State of Maryland and CareFirst to improve quality of care and access to care thereby reducing health care disparities and promote better health outcomes. The information you provide will not have a negative impact on any services we provide you. The information is kept strictly confidential and will not be shared unless required by law to disclose it.

Race
- White/Caucasian
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Other – (To include Multi-Racial)
- Decline to answer
- Unknown – Could not be determined

Ethnicity
- Hispanic/Latino/Spanish origin

Preferred Spoken Language*
- 01 English
- 02 Albanian
- 03 Amharic
- 04 Arabic
- 05 Burmese
- 06 Cantonese
- 07 Chinese (simplified & traditional)
- 08 Creole (Haitian)
- 09 Farsi
- 10 French (European)
- 11 Greek
- 12 Gujarati
- 13 Hindi
- 14 Italian
- 15 Korean
- 16 Mandarin
- 17 Portuguese (Brazilian)
- 18 Russian
- 19 Serbian
- 20 Somali
- 21 Spanish (Latin America)
- 22 Tagalog (Filipino)
- 23 Urdu
- 24 Vietnamese
- 98 Other and unspecified languages
- 99 Unknown

	Last Name	First Name	Race	Ethnicity	Country of Origin	Preferred Spoken Language (*specify number from above)
Primary Applicant						
Spouse/ Domestic Partner						
Dependent 1						
Dependent 2						
Dependent 3						
Dependent 4						
Dependent 5						
Dependent 6						
Dependent 7						
Dependent 8						

FOR OFFICE USE ONLY: ☐ Re-sign and re-date below only if box is checked.	
Signature of Primary Applicant: X	Date
Signature of Applicant 2: X (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
Contracted Broker:	**Benefit Indemnity Corporation**			**B89F**
Writing Agent:	**Nicole Cavender**	*****-**-3262**		