



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

## Enrollment Form (Virginia Groups)

**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	Effective Date Requested / /	Group Number
--------------------------------	---------------------------------	--------------

**II. ENROLLEE**

Social Security Number	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name	First Name	Middle Initial
Date of Hire / /	Occupation	Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired
Residence Address (Number and Street) (City and State) (Zip Code – 9-digit, if known)		
Home Phone ( )	Work Phone ( )	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Email Address		

**III. TYPE OF ENROLLMENT**

**CHECK ONE:**  New  Coverage Change

**IV. TYPE OF COVERAGE**

To avoid delays in processing this form, please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section.

<p><b>CHECK ONE:</b></p> <input type="checkbox"/> Individual <input type="checkbox"/> Individual and Adult <input type="checkbox"/> Individual and Child <input type="checkbox"/> Individual and Children <input type="checkbox"/> Family <input type="checkbox"/> Coverage Complementary to Medicare (Individual only and benefit coverage only; not eligible for HSA)	<p><b>IF ENROLLING FOR MEDICAL COVERAGE, CHECK ONE:</b></p> <input type="checkbox"/> BluePreferred, Option _____ <input type="checkbox"/> BlueFund BluePreferred HRA, Option _____ <input type="checkbox"/> BlueFund BluePreferred HSA, Option _____ <input type="checkbox"/> BluePreferred HRA Compatible, Option _____ <input type="checkbox"/> BluePreferred HSA Compatible, Option _____ <input type="checkbox"/> Other	<p><b>CHECK ALL APPLICABLE:</b></p> <input type="checkbox"/> Preferred Dental <input type="checkbox"/> Traditional Dental <input type="checkbox"/> BlueVision Plus
--	--	--

**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: \_\_\_\_\_

<input type="checkbox"/> ADD dependent(s) listed in Section VI <input type="checkbox"/> ADD spouse due to marriage on _____ (Date) <input type="checkbox"/> ADD domestic partner on _____ (Date) <input type="checkbox"/> ADD child due to adoption on _____ (Date) or appointed legal guardian by court decree dated _____  <p><b>(Note: Documentation of adoption or court-appointed legal guardianship must be provided)</b></p>	<input type="checkbox"/> REMOVE dependent(s) listed in Section VI due to _____ (Reason) on _____ (Date) <input type="checkbox"/> CHANGE address to that shown in Section II <input type="checkbox"/> CHANGE my name from _____ to that shown in Section II
--	---

**VI. DEPENDENT INFORMATION**

1	Spouse	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address
2	Domestic Partner	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address
3	Child	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address
4	Child	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address
5	Child	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address
6	Child	Name – (Last, First, MI)	Coverage Level <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> BlueVision Plus	Social Security Number
		Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address

**COMPLETE ONLY IF CHILD IS A STUDENT (AGE 26 OR OLDER) OR DISABLED**

If child is a student age 26 or older, please confirm coverage with your employer prior to completing this section.

Child Name – (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, Attach Student Certification Form</b>	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, Attach Disability Certification Form and Supporting Documentation</b>
Child Name – (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> 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 \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_ Reason for entitlement:  Age 65 or older  Kidney disease  Disabled

Medicare Claim No. \_\_\_\_\_ Eligible for:  Part A Eff. Date \_\_\_/\_\_\_/\_\_\_  Part B Eff. Date \_\_\_/\_\_\_/\_\_\_

ENROLLEE 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                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | E. Dental                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. Physician Services                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | F. Eye / Vision Care Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Major Medical (out-of-pocket expenses) | <input type="checkbox"/> Yes <input type="checkbox"/> No | G. Mental Illness Services    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. Separate Drug Program                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | H. HMO                        | <input type="checkbox"/> Yes <input type="checkbox"/> 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 children.

Please indicate relationship to children:

PARENT WITH COURT-ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES	_____	PARENT WITH CUSTODY OF CHILD(REN)	_____
	<i>Parent's Name / Relationship</i>		<i>Parent's Name / Relationship</i>
	_____		_____
	<i>Child's Name / Date of Birth</i>		<i>Child's Name / Date of Birth</i>

**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. Coverage will be provided according to the terms and conditions of the contract between 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 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 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

You can receive electronic notices via email instead of paper notices for your CareFirst health care coverage by providing your consent below.

- These will include but are not limited to:
  - Explanation of Benefits alerts
  - Appeal decision alerts
  - Notice of HIPAA Privacy Practices
  - 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.

- You may change your email and consent information anytime by logging into [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount) or by calling the customer service phone number on your ID card.
- You can request a paper copy of electronic notices at anytime by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically, 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).

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

Member Name	Signature

By signing below, my spouse and any dependents covered by CareFirst individually agree to electronic delivery of notices and documents:

Spouse/Dependent Name	Signature

CareFirst will not sell your email address to any third party and we do not share it with third parties except for CareFirst vendors that perform functions on our behalf or to comply with the law.