

Individual Open Enrollment Application

(District of Columbia Residents)



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

ID #:	CLASS/PLAN:
GROUP #:	EFF DATE:

INSTRUCTIONS

- Please fill out all applicable spaces on this application. Print or type all information.
- Sign and return this application in the postage-paid return envelope.

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 delay your coverage.

1. APPLICANT INFORMATION

Last Name		First Name		Initial	Social Security Number
Residence Address (Number and Street)			(City and State)	(Zip Code-9-digit, if known)	
Billing Address, if different from Residence Address: (Number and Street)			(City and State)	(Zip Code-9 digit, if known)	
Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single			
Home Phone ()	Work Phone ()	E-mail Address			

2. COVERAGE

TYPE OF COVERAGE ELECTED (CHECK ONE):

Self-Only Two-Party (Subscriber and Spouse) Two-Party (Subscriber and Child) Family

(NOTE: Section 3 must be completed if enrolling for Two-Party or Family Coverage)

3. ENROLLING FAMILY MEMBERS (COMPLETE ONLY IF YOU SELECT TWO-PARTY OR FAMILY COVERAGE)

LAST NAME	FIRST NAME AND MIDDLE INITIAL	RELATIONSHIP	SOCIAL SECURITY NO.	DATE OF BIRTH Month Day Year	SEX
			- -		<input type="checkbox"/> M <input type="checkbox"/> F
			- -		<input type="checkbox"/> M <input type="checkbox"/> F
			- -		<input type="checkbox"/> M <input type="checkbox"/> F
			- -		<input type="checkbox"/> M <input type="checkbox"/> F
			- -		<input type="checkbox"/> M <input type="checkbox"/> F
			- -		<input type="checkbox"/> M <input type="checkbox"/> F

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee 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.

4. MEDICARE COVERAGE

Check this block if any persons listed on this application are eligible for or are receiving benefits under Medicare.
If you checked the block, please give:

Name: _____ Medicare Claim No.: _____

Eligible for: Part A Eff. Date ____/____/____ Part B Eff. Date ____/____/____

Reason for entitlement: Age 65 or older End stage renal disease Disabled

Beginning date of renal treatment, if applicable: ____/____/____

Name: _____ Medicare Claim No.: _____

Eligible for: Part A Eff. Date ____/____/____ Part B Eff. Date ____/____/____

Reason for entitlement: Age 65 or older End stage renal disease Disabled

Beginning date of renal treatment, if applicable: ____/____/____

5. OTHER COVERAGE

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

5a. Check this block if any person listed on this application 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, or another insurance carrier or Medicaid. Is this coverage in effect? Yes No

5b. If Yes, will this coverage be continued? Yes No If No, please provide cancellation date ____/____/____

If you answered "Yes" to question 5a, please complete the following.

1. Policy Holder's Name: _____ Sex: M F Date of Birth ____/____/____

2. Name and Location of Insurance Company: _____

3. Policy Number: _____ Policy covers: Policy Holder Only Two-Party Family

4. Effective Date of Policy: ____/____/____

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. HMO Yes No

D. Separate Drug Program Yes No H. Maternity Services Yes No

6. Is coverage through an employer or other group? Yes No I. Mental Illness Yes No

If Yes, name of employer or other group: _____

7. Is coverage through an individual insurance policy? Yes No

I, _____, have enclosed the sum of \$ _____ in payment of subscription charges for which this application has been signed.
(Name of Applicant)

Coverage will not become effective until all the conditions shown below have been met. These conditions can not be altered or waived by any agent or broker.

1. The application must be completed in full and must be approved by Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield (hereafter "CareFirst").
2. Payment of subscription charges must accompany this application, or the application will be returned. The check must be honored on first presentation for payment.
3. The applicant and any eligible family member(s) must be eligible for coverage as determined by CareFirst and as communicated by CareFirst to the applicant in writing.
4. The contract will become effective on the first day of the month following final approval of the application by CareFirst or as determined by CareFirst.

If one of the above conditions are not met, CareFirst will incur no liability under this Section except to return any subscription charges actually received by CareFirst in connection with this application. Interest will not be paid by CareFirst in connection with any refund of subscription charges actually paid by the applicant.

ADDITIONALLY, IT IS UNDERSTOOD AND AGREED THAT:

(a) The contract applied for does not offer benefits for obstetrical care or for any condition resulting from or arising out of and during pregnancy. Exception: Benefits will be considered for obstetrical care for complications of pregnancy, as outlined in your contract.

(b) The Subscriber shall repay to CareFirst the amount of any payment(s) made in error to the Subscriber or on behalf of the Subscriber or any covered family member as the result of a claim.

(c) A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request. If this application is accepted by CareFirst, a copy of this application will be attached to the contract issued to the Subscriber.

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. I understand that a medically underwritten policy is only issued under the condition that the health of all persons named on the application remains as stated above. I also understand that failure to enter accurate, complete and updated medical information may result in the denial of benefits, cancellation or voiding of my policy.

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

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 BEFORE SIGNING THIS APPLICATION.

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

Signature of Applicant: **X** _____ Date: _____

840 First Street, NE
 Washington, DC 20065
 (202) 484-9100

BluePreferred Open Enrollment for the District of Columbia
Initial Two-Month Payment Request
Rates Effective January 1, 2005



Name: _____
 Address: _____
 City/State/Zip: _____

DO NOT WRITE IN THIS SPACE											
Identification No.						Group No.					
Effective Date				Class/Index Code				Paid Status			
1	2	3	4	5	6	7	8	9	10	11	12
IACS No.								Rep/Broker 176-521691146 201077046			

Contract Holders Age	TYPE of Coverage (circle one):			
	INDIVIDUAL	INDIVIDUAL + CHILD	INDIVIDUAL + ADULT	FAMILY
<21	\$292	\$470	\$586	\$790
21	\$298	\$478	\$594	\$804
22	\$302	\$484	\$604	\$814
23	\$312	\$498	\$624	\$842
24	\$318	\$508	\$634	\$856
25	\$322	\$518	\$644	\$866
26	\$332	\$532	\$662	\$896
27	\$336	\$536	\$672	\$904
28	\$342	\$546	\$682	\$920
29	\$350	\$562	\$702	\$944
30	\$354	\$572	\$712	\$958
31	\$364	\$586	\$730	\$986
32	\$370	\$594	\$740	\$996
33	\$380	\$610	\$760	\$1,026
34	\$384	\$614	\$770	\$1,034
35	\$394	\$634	\$788	\$1,064
36	\$400	\$638	\$796	\$1,074
37	\$408	\$654	\$816	\$1,102
38	\$418	\$672	\$836	\$1,126
39	\$422	\$676	\$844	\$1,142
40	\$432	\$692	\$864	\$1,164
41	\$452	\$724	\$902	\$1,218
42	\$474	\$764	\$952	\$1,248
43	\$494	\$792	\$990	\$1,334
44	\$520	\$832	\$1,038	\$1,400
45	\$542	\$870	\$1,086	\$1,462
46	\$568	\$908	\$1,134	\$1,530
47	\$590	\$948	\$1,182	\$1,592
48	\$620	\$994	\$1,240	\$1,676
49	\$650	\$1,038	\$1,298	\$1,752
50	\$678	\$1,086	\$1,356	\$1,828
51	\$708	\$1,134	\$1,414	\$1,906
52	\$740	\$1,188	\$1,480	\$1,998
53	\$774	\$1,240	\$1,548	\$2,088
54	\$808	\$1,292	\$1,616	\$2,182
55	\$846	\$1,356	\$1,694	\$2,286
56	\$886	\$1,418	\$1,768	\$2,386
57	\$928	\$1,486	\$1,856	\$2,504
58	\$966	\$1,548	\$1,934	\$2,610
59	\$1,016	\$1,626	\$2,030	\$2,740
60	\$1,058	\$1,694	\$2,116	\$2,854
61	\$1,106	\$1,768	\$2,212	\$2,986
62	\$1,106	\$1,768	\$2,212	\$2,986
63	\$1,106	\$1,768	\$2,212	\$2,986
64	\$1,106	\$1,768	\$2,212	\$2,986
65	\$1,106	\$1,768	\$2,212	\$2,986
>65	\$1,106	\$1,768	\$2,212	\$2,986

MAKE CHECK PAYABLE TO CAREFIRST – THIS NOTICE MUST BE RETURNED WITH YOUR PAYMENT
 Final approval for enrollment will be considered upon receipt of your application and payment. Coverage will become effective the first of the month following approval of your application.

Policy Form Numbers:
 D-CMM/MM ATTB/DB-4/96 • DC/C-OE 3/99 • DC/DP-IEA-9/95 • PPP-A/DC-4/96 • BODDCAP (3/03) • DC/CF/IND RX3 (1/03) and any amendments.
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