



## V. DEPENDENT INFORMATION

1	Spouse/ Partner	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
2	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
3	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
4	Child	Name - (Last, First, MI)	Social Security No.	Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		Name of Primary Care Physician		Physician Code #	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No

### COMPLETE ONLY IF DEPENDENT CHILD IS A STUDENT OR DISABLED

Dependent Name - (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH STUDENT CERTIFICA- TION FORM	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, ATTACH DISABILITY CERTIFICATION Form AND SUPPORTING DOCUMENTATION
Dependent Name - (Last, First, MI)	Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## VI. MEDICARE COVERAGE

FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, WILL CAUSE SIGNIFICANT PROCESSING DELAYS.

Check this block if any person listed on this Form is eligible for or receiving benefits under Medicare. If you checked the block, 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 \_\_\_/\_\_\_/\_\_\_

EMPLOYEE STATUS: (CHECK ONLY ONE BOX)  Actively Employed  Retired

**VII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION (continued)**

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

Check this block 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 \_\_\_\_\_ 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 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

5. Service(s) Covered: month day year

- |   |  |                             |  |
|---|--|-----------------------------|--|
| 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 Reason for cancellation \_\_\_\_\_

8. To be completed if the natural parents live apart and provide medical coverage for their children.  
 Please indicate relationship to children (natural mother, natural father, step-parent)

PARENT WITH COURT ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES \_\_\_\_\_  
*Parent's Name / Relationship*  
 \_\_\_\_\_  
*Child's Name / Date of Birth*

PARENT WITH CUSTODY OF CHILD(REN) \_\_\_\_\_  
*Parent's Name / Relationship*  
 \_\_\_\_\_  
*Child's Name / Date of Birth*

**VIII. PLEASE READ CAREFULLY - THIS SECTION MUST BE DATED AND SIGNED**

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this Form is accepted, coverage will be provided according to the terms and conditions of the contract between CareFirst BlueChoice, Inc. 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 subscription charges to my employer.

**Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

**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. 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 enrollment for coverage.**

**NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under the coverage for which you are applying, please contact a membership services representative before signing this Form.**

X \_\_\_\_\_  
 Signature of Applicant Date