

INSTRUCTIONS

Please review all sections of this application and complete them according to the instructions. An incomplete application WILL BE RETURNED and may result in a delay of your membership.

1. TYPE OF REQUEST

Check the NEW MEMBERSHIP box if you are applying for the first time through your current employer and complete Sections 2 through 7.

Check the CHANGE OF COVERAGE box if you have an existing membership and wish to increase or decrease your coverage level in Section 5. You must complete Sections 2 through 7.

Check the CHANGE OF SUBSCRIBER or DEPENDENT INFORMATION box if correcting information in Sections 2, 3, 4, 6, or 7. Complete your name and membership number in Section 2.

Check the RE-ENROLLMENT box if your employer is requesting all employees to complete an application.

Check the TERMINATION OF DEPENDENTS box ONLY if you have FAMILY coverage and will still have 2 or more dependents after terminating the dependent(s). Complete your name and membership number in Section 2. If the termination of the dependent(s) will result in a coverage level change do not complete Section 8, complete Sections 2 through 7.

2. SUBSCRIBER INFORMATION SECTION

1. ALWAYS print your full name, address and social security or CareFirst BlueCross BlueShield membership number on this form.

2. Write your date of hire in the employment date box.

3. Check either active or retired in the employment status box.

4. Check your sex type.

5. Write your date of birth.

6. Write both of your telephone numbers.

7. Check your marital status.

8. Write your date of marriage if applicable.

9. Write the name of your employer.

10. Do not complete the four shaded boxes in this section.

3. MEDICARE AND TEFRA INFORMATION SECTION

1. If you have Medicare insurance, write the number that appears on your Medicare card on the Hospital Insurance Claim No. line.

2. Also write the effective dates of the Hospital and/or Medical insurance.

3. This item needs to be completed only when your employer informs you of TEFRA information.

a. Select a primary carrier for yourself and your spouse if applicable.

4. OTHER HEALTH INSURANCE INFORMATION

1. Complete the name of your spouse's employer.

2. If any dependent has health insurance, complete the six items; name and birthdate of the covered person, insurance company name, location, employer name and policy number.

3. If covered by any other CareFirst BlueCross BlueShield write the membership number, city and state of the plan.

5. COVERAGE LEVEL SELECTION SECTION

1. Check the coverage level you want for yourself and your eligible dependents.

6. GENERAL DEPENDENT INFORMATION SECTION

1. Write an A when adding a dependent for a new membership or existing membership. Write a C if you are changing information about a dependent already covered.

2. Write the last name ONLY if different than yours, the full first name and middle initial of each eligible dependent.

3. Check the sole support box if you provide support (as defined by the IRS) for a child who has a different last name.

4. Write M or F to indicate the sex of the dependent.

5. Write the date of birth for each dependent.

6. Write the social security number for each dependent.

7. If you have more than 6 dependents, complete Section 6 of a second form and attach it to the back.

7. DETAILED DEPENDENT INFORMATION SECTION

1. Write the name and Medicare number of your dependents who are covered by Medicare.

2. Write the name of your disabled dependents that are incapable of self support because of mental retardation or physical incapacity, the date they became disabled and complete a Disability Qualification Questionnaire (Form 1.31).

3. Write the name and school of any dependents who are full time college students.

8. TERMINATION OF DEPENDENT SECTION

1. You may stop the benefits for a dependent by writing your dependent's name, effective date and the reason code for termination.

2. If removing the last child of your Family coverage, you must check the CHANGE OF COVERAGE box at the top and complete Sections 2 through 7.

You MUST sign and date this application form to obtain health insurance benefits. It will be returned to your employer if your signature and date are omitted. If you completed TEFRA information in Section 3 and you are married, then your spouse must also sign this application.