

V. DEPENDENT INFORMATION

1	Spouse	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	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
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
5	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 or another insurance carrier. 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.

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.

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.

X _____
Signature of Applicant

Date