

Individual Select Preferred Dental Application



OFFICE USE ONLY:

(Maryland 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 #
Residence Address: (Number and Street, Apt. #)			City and State	Zip Code (9-digit, if known)	
Business Address, if different from Residence Address: (Number and Street, Apt. #)			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"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner		Plan Type <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual	
Home Phone ()	Work Phone ()	E-mail Address			

2. COVERAGE SELECTION: (Check one)

- Individual** - Provides coverage for one person
- Individual & Child(ren)** - Provides coverage for an individual and eligible dependent(s)
- Individual & Adult** - Provides coverage for two eligible adults
- Family** - Provides coverage for up to two eligible adults and eligible dependent(s)

3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child(ren), Individual & Adult or Family Coverage

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX
Member						<input type="checkbox"/> M <input type="checkbox"/> F
Spouse/Partner						<input type="checkbox"/> M <input type="checkbox"/> F
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F

4. OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED. YES NO

Is anyone listed on this application covered by other dental insurance, including other Blue Cross and Blue Shield coverage? YES NO

If yes, please provide the following:

Name of family member(s) _____ Insurance Company _____

Policy Number and Type _____ Effective Date _____

5. CONDITIONS OF ENROLLMENT – Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.

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.

Premium payment options are available on an annual and a semiannual basis. Those members who elect the semiannual payment option will be subject to a five dollar (\$5) surcharge per payment, which equates to ten dollars annually.

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.

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: 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.

Signature of Applicant: X _____ Date: _____

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

Parent or Legal Guardian Signature: X _____ Date: _____

Please make checks payable to: 



CAREFIRST BLUECROSS BLUESHIELD
and mail to: #20220
P.O. Box 79810
Baltimore, MD 21279-0810

FOR INTERNAL USE ONLY:

Agency Name **JEFF MOTSCO 20220**

Agency Address (Number and Street, Apt.#) **5965 SANDY RIDGE** (City and State) **ELKRIDGE MD** Zip Code (9-digit, if known) **21075**

Telephone Number () 4107967497	Fax Number () 4107967456	E-mail Address
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Annual Premium



Individual Select Preferred Dental Rates *Maryland*

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application
Individual	\$151.80
Individual & Child(ren)	\$280.80
Individual & Adult	\$349.20
Family	\$425.04

Coverage Type	Semi-Annual Rate Second Payment Due by the first of the seventh month from the effective date of coverage	
	1ST PAYMENT	2ND PAYMENT
Individual	\$80.90	\$80.90
Individual & Child(ren)	\$145.40	\$145.40
Individual & Adult	\$179.60	\$179.60
Family	\$217.52	\$217.52

Please note that when selecting the semi-annual payment, a \$5.00 administration fee is already included into each payment. You pay an additional \$10/year when you select the semi-annual payment option. The first payment (of the semi-annual rate) is due with the enrollment application. The second payment is due by the first of the seventh month from the effective date of coverage.

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.



Individual Select
Preferred Dental Coverage
Maryland

More to feel good about.

Did You Know...

- Pregnancy can cause swelling, bleeding, redness, or tenderness in the gum tissue due to hormonal changes.
- Women less than 35 weeks pregnant who receive treatment for gum disease have 84% fewer premature births.¹
- People with periodontal disease are 2-4 times more likely to have a heart attack.²
- Diabetic patients with periodontal disease have more difficulty controlling blood glucose levels.³

¹ Lopez NJ, et al. Periodontal therapy reduces the rate of preterm low birth weight in women with pregnancy-associated gingivitis. *J Periodontol.* 2005 Nov;76(11 Suppl):2144-53.

² Andriankaia, OM, et al. The use of different measurements and definitions of periodontal disease in the study of the association between periodontal disease and risk of myocardial infarction. *J Periodontol* 2006 Jun;77(6):1067-73

³ Faria-Almeida R, Navarro A, Bascones A. Clinical and metabolic changes after conventional treatment of type 2 diabetic patients with chronic periodontitis. *J Periodontol.* 2006 Apr;77(4):591-8.

Protect Your Best Feature – *Your Smile*

Your smile says a lot about you. It's the first thing people see when they meet you. A healthy smile can make you more appealing, even more youthful. But did you know your smile also says a lot about your overall health?



That's why it's so important to protect your smile. Good dental care has been scientifically shown to reduce your risk of heart disease; it helps to control diabetes, and can even prevent premature births.

CareFirst BlueCross BlueShield brings you **Individual Select Preferred Dental** which offers:

- **Lower cost**
- **More than 3,400 dentists throughout Maryland, DC and Northern Virginia**
- **Easy enrollment**
- **No deductibles**
- **No referrals**
- **No claims forms to file in network**
- **Guaranteed acceptance**

Just think – a better smile and better health – all for just *pennies a day*.

Ready to protect your smile – your health? *Read on!*

Individual Select Preferred

Comprehensive coverage of preventive services, additional in-network savings for major procedures, and your choice of 3,400+ participating dentists

Individual Select Preferred combines the freedom to select any dentist from a large regional network with comprehensive coverage of preventive and diagnostic dental services such as:



- **Examinations**

- **Cleanings**

- **X-rays**

These services are covered in full when visiting an in-network provider. You'll also have the option to seek routine treatment from non-participating providers and continue to receive benefits.[†]

With **Individual Select Preferred**, you'll enjoy additional in-network savings on non-covered dental procedures, including fillings, crowns, and orthodontia. To take advantage of these reduced rates, you must visit a participating dentist.^{**}

^{*} NOTE: CareFirst payments are based on the Individual Select Preferred Allowed Benefit. Participating dentists accept 100% of the Allowed Benefit from CareFirst as payment in full for covered services. If you visit a non-participating dentist for routine services, you must submit a claim form to CareFirst for reimbursement. You will be responsible for the difference between the Individual Select Preferred Allowed Benefit and a non-participating provider's full charges.

^{**} This portion of the plan is not an insurance product. Member charges are based on Individual Select Preferred allowances with the participating providers. Since rates vary by provider, members should check with their participating dentist to determine the costs of specific procedures. Members must pay these reduced rates directly to the provider during the office visit.

Maria



Maria is a single, healthy 30-year-old web designer who has just moved to Maryland. She has an individual health insurance plan to cover medical expenses, but she never thought about dental coverage. Maria visits her local dentist twice a year for her routine cleanings and exams. Maria would have saved over \$200 with **Individual Select Preferred**.

	No Coverage	Individual Select Preferred Plan	Savings
6 month check-ups with x-rays	\$225* (for both visits)	\$0 in-network (both visits are covered)	\$225

* Based on National Dental Advisory Service Fee Report (2006).

With no dental coverage, Maria was paying for her bi-annual check-ups. She chose to enroll in the **Individual Select Preferred** plan. Her current dentist is a participating provider, so her six-month check-ups are now covered in full and she saved \$225. With **Individual Select Preferred**, Maria also has the freedom to try out different general dentists and specialists in her area whenever she likes. With 3,400+ participating providers in MD, DC and VA, she has plenty of choices!

The Smiths



Mildred and Charles Smith are active retirees who recently took up golf. They have Medicare and have purchased a supplemental Medicare product to protect themselves against medical costs. They didn't think about how their budget might be impacted by major dental expenses until Mildred needed root canal therapy and Charles needed a bridge.

	No Coverage	Individual Select Preferred Plan	Savings
6 month check-ups with x-rays (4 visits, 2 per person)	\$450*	\$0 in-network (all visits are covered)	\$450
Root Canal (Bicuspid)	\$695*	\$435**	\$260
Bridge (3-Unit)	\$2,650*	\$1,890**	\$760
Total	\$3,795	\$2,325	\$1,470

* Based on National Dental Advisory Service Fee Report (2006).
 ** Prices are approximate, depending upon services and the contractual rate agreed upon between the dentist you use and the plan.

With no dental coverage, the Smiths paid \$3,795 for these dental services. They decided to purchase dental coverage to protect themselves against further unexpected dental costs. With **Individual Select Preferred** coverage, the Smiths would have spent \$2,325, a savings of over \$1,400 on these dental services. Now they're covered and ready for whatever lies ahead!

Individual Select Preferred

Benefits at a Glance

Common Dental Procedures and Their Costs	Regular Cost*	You Pay
Biannual check-ups, including routine exams, cleanings and x-rays	\$225 (2 visits per year)	No charge in-network
Simple tooth extraction	\$135	Reduced rates from in-network providers typically between \$69 - \$93**
Periodontal scaling and root planning (four or more teeth per section of the mouth)	\$210	Reduced rates from in-network providers typically between \$116 - \$137**
Porcelain crown (High noble metal)	\$915	Reduced rates from in-network providers typically between \$575 - \$680**
Complete Upper Dentures	\$1,375	Reduced rates from in-network providers typically between \$665 - \$800**
Orthodontics (Adolescent)	\$4,890	Reduced rates from in-network providers typically between \$2,900 - \$4,700**

* Based on National Dental Advisory Service Fee Report (2006).

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It's Easy to Enroll.

To protect your smile with this exclusive offer, just follow these simple steps:

- **Fill out and sign the enclosed application.**
- **Choose annual or semi-annual payment.**
- **Send in your application, with your premium payment, in the enclosed, postage paid envelope.**

This is a partial listing of covered services. For specific questions, please contact customer service toll-free at 1-888-833-8464.

CareFirst will mail you your membership cards and certificate of coverage. Then you can start enjoying all the benefits of your coverage – and the benefits of good dental care. When you're ready to review a listing of providers, please visit www.carefirst.com.

Policy Form Numbers:
FORM DN001C (10/2006)
FORM DN4001 (3/07)
JDMMDAP (3/08)



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Washington, DC 20065

www.carefirst.com

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