

Individual Personal Comp Application

(Maryland Residents)



10455 Mill Run Circle
Owings Mills, Maryland 21117

OFFICE USE ONLY:

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 if provided, or mail to:
APPLICATION PROCESSING
5965 SANDY RIDGE
ELKRIDGE, MARYLAND 21075

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.

FAX COMPLETED APPLICATION TO:
1-877-877-5801 OR 1-410-796-7456

OR MAIL TO:
APPLICATION PROCESSING
5965 SANDY RIDGE
ELKRIDGE, MD 21075

YOU WILL RECEIVE A CONFIRM E-MAIL WITHIN 24-48 HOURS OF RECEIPT

1. APPLICANT INFORMATION (The oldest applicant will be the Policyholder)

Last Name	First Name	Initial	Social Security #
Residence Address: (Number and Street, Apt. #)		City and State	Zip Code (9-digit, if known)
Billing 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	Height Weight
Home Phone ()	Work Phone ()	E-mail Address	

2. COVERAGE SELECTION: (Check one)

- Individual** - Provides coverage for one person
- Individual & Child** - Provides coverage for an individual and one eligible dependent
- Individual & Adult** - Provides coverage for two eligible adults
- Family** - Provides coverage for two eligible adults and eligible dependent(s) or an individual with more than one eligible dependent

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

Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	HEIGHT (in.)	WEIGHT (lbs.)
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		
Dependent 5						<input type="checkbox"/> M <input type="checkbox"/> F		

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:	Pinion Financial Services LLC	75-306-9661	48E
Sub-Agent/Sub-Agency:	J. Motsco		
Writing Agent:	J. Motsco		

CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, 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. COVERAGE LEVEL DESIRED

IMPORTANT HEALTH SAVINGS ACCOUNT-COMPATIBLE COVERAGE INFORMATION: For purposes of deductible and out-of-pocket limit amounts, any coverage level selection which is not Individual is considered to be Family. The Family category includes Individual and Child, Individual and Adult, and Family. If the Policy category is Family, there is no individual annual deductible or individual out-of-pocket limit. If the coverage level selection is Family, only when the Family aggregate deductible is reached by one or more members of the Family will no further deductible amounts be charged for the remainder of the calendar year. The Family deductible must be reached before CareFirst BlueCross BlueShield pays benefits for any member in a Family Policy category.

If the coverage level selection is Family, only when the Family aggregate out-of-pocket amount is reached by one or more members of the Family will no further deductible or coinsurance amounts be charged for the remainder of the calendar year. Once the out-of-pocket limit is reached, members in a family category will no longer be responsible for deductible and coinsurance amounts for that calendar year.

Individual Deductible	Coverage Level	Coinsurance	Individual Out-of-Pocket Limit (except where marked)
<input type="checkbox"/> \$100	80%	20%	\$1,000
<input type="checkbox"/> \$200	80%	20%	\$2,000
<input type="checkbox"/> \$400	75%	25%	\$2,000
<input type="checkbox"/> \$500	80%	20%	\$2,000
<input type="checkbox"/> \$800	75%	25%	\$2,000
<input type="checkbox"/> \$1,000	80%	20%	\$2,500
<input type="checkbox"/> \$1,700*	80%	20%	\$4,000 (Individual)/ \$8,000 (Family)
<input type="checkbox"/> \$2,500*	100%	0%	\$2,500 (Individual)/ \$5,000 (Family)
<input type="checkbox"/> \$2,500	80%	20%	\$4,000
<input type="checkbox"/> \$5,000	80%	20%	\$6,000
<input type="checkbox"/> \$10,000	80%	20%	\$10,000

*Health Savings Account - Compatible Plans. Please refer to Information above regarding the Out-of-Pocket Maximums.

VISION BENEFITS: Check if you wish to include benefits for vision services (additional cost).

Yes

5. OTHER INSURANCE INFORMATION

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

1. Is anyone listed on this application eligible for Medicare? YES NO

If yes, please provide the following:

Name of family member(s) _____ Medicare No _____ Effective Date _____

2. Is anyone listed on this application covered by other health 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 _____

If you are accepted, will your new CareFirst BlueCross BlueShield coverage replace your existing policy? YES NO

3. Has anyone listed on this application been without health insurance for the past 12-months or longer? YES NO

If yes, please list name(s): _____

6. HEALTH EVALUATION

PLEASE COMPLETE SECTIONS A, B AND C. CHECK EACH ITEM "YES" OR "NO". Answering yes will not necessarily result in the rejection of your application. YES NO

Have you or any family member named in this application had a physical examination within the past five years? YES NO

SECTION 6A — If any person included in this application is presently using or has used medication or prescription drugs in the past 5 years, please provide the following information.

Name of Family Member	Illness or Condition	Medication	Date of Last Treatment	How Often Taken	Attending Physician Name and Address

6. HEALTH EVALUATION (Continued)

SECTION 6B – To the best of your knowledge and belief, has any person named in this application had within the last five years, or does such person now have, any of the following:	YES	NO
1. Cancer, tumor or other growth (malignant or benign)	<input type="checkbox"/>	<input type="checkbox"/>
2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test)	<input type="checkbox"/>	<input type="checkbox"/>
3. Kidney stones, kidney or bladder condition, urinary frequency or burning	<input type="checkbox"/>	<input type="checkbox"/>
4. Goiter, thyroid condition, diabetes	<input type="checkbox"/>	<input type="checkbox"/>
5. Seizure disorder, central nervous system disorder, multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
6. Substance abuse (drug or alcohol dependency, abuse or addiction)	<input type="checkbox"/>	<input type="checkbox"/>
7. Use of illicit drugs	<input type="checkbox"/>	<input type="checkbox"/>
8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	<input type="checkbox"/>	<input type="checkbox"/>
9. Cataract or other eye condition	<input type="checkbox"/>	<input type="checkbox"/>
10. Tuberculosis, lung condition, asthma, bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	<input type="checkbox"/>	<input type="checkbox"/>
12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)	<input type="checkbox"/>	<input type="checkbox"/>
13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, breast condition	<input type="checkbox"/>	<input type="checkbox"/>
14. (Female) Is currently pregnant; expected date of delivery: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
15. (Male) Prostate condition, reproductive system disorders	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you or your spouse/partner have known infertility or any known disorder related to infertility	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you or your spouse/partner received any treatment or diagnostic “work-up” related to infertility	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you been told that you have high or elevated cholesterol, lipids or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
19. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	<input type="checkbox"/>	<input type="checkbox"/>
20. Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
21. Anemia, blood disorders	<input type="checkbox"/>	<input type="checkbox"/>
22. Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or prescription medication for a medical condition NOT listed above in items 1-21?	<input type="checkbox"/>	<input type="checkbox"/>
23. Had any known departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought?	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” – Or your application will be returned.

SECTION 6C – If you have checked “YES” to any part of SECTION 6B, for each box checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

NOTE: FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN VOIDING OF MEMBERSHIP AND DENIAL OF BENEFITS.

Patient's First Name	Question Number	Diagnosis or Condition	Duration Dates	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician's/hospital's name.	Recovery (Check only one box)
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL

7. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A Copy of this application is available to the Policyholder (or to a person authorized to act on his/her behalf) upon request, from CareFirst BlueCross BlueShield (CareFirst).

This information is subject to verification. To do so I authorize any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company to release my "Medical Information" to CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst) or CareFirst's vendors or representatives. I further authorize any vendor who receives "Medical Information" from any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company to release my "Medical Information" to CareFirst. I understand that my Medical Information consists of any diagnoses, treatment, prescriptions from a pharmacy, or any other medically related information about me. I authorize CareFirst to use my Medical Information for underwriting and to determine my eligibility for insurance benefits. I understand this authorization will remain in effect for one year from the date signed.

I understand that I have the right to cancel this authorization at any time, in writing, except to the extent that CareFirst has already taken action in reliance on this authorization. I also understand that CareFirst's Notice of Privacy Practices includes information pertaining to authorizations and to requirements of revocation. A copy of the Notice may be obtained by contacting the CareFirst Privacy Office. CareFirst will not use or disclose the Medical Information for any purposes other than those listed above except as may be required by law. CareFirst is required to tell you by law that information disclosed pursuant to this authorization may be subject to re-disclosure and that under some limited circumstances will no longer be protected by federal privacy regulations.

If CareFirst determines that additional information is needed, I will receive an authorization to release that information. Failure to execute an authorization may result in the denial of my application for coverage. Additionally I understand that failure to complete any section of this application, including signing below, may delay the processing of my application.

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 the CareFirst policy. I understand that a medically underwritten policy is only issued under the conditions 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 all benefits, cancellation or voiding of my policy.

I will update CareFirst if there have been any changes in health concerning any person listed in this application that occurs prior to acceptance of this application by CareFirst.

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.

An applicant or dependent whose Application is denied by CareFirst due to medical underwriting may not submit a subsequent Application for enrollment within ninety (90) days of the denial.

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 1:* X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____
(Spouse/Partner)

* Rates are based on the age of the Policyholder (oldest applicant).

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's Signature: X _____ Date: _____

FOR OFFICE USE ONLY:

Re-sign and re-date below only if box is checked.

Signature of Applicant 1: X _____ Date: _____

Signature of Applicant 2: X _____ Date: _____
(Spouse/Partner)