MEMBERSHIP APPLICATION

PLEASE PRINT – PRESS FIRMLY

PLEASE READ!
This is for HEALTH INSURANCE ONLY. Dental and Vision require separate forms. Contact HR to obtain dental and vision forms.

CareFirst BlueCross BlueShield
10455 Mill Run Circle, Owings Mills, MD 21117

ADDRESS CHANGE

1. TYPE OF REQUEST ☐ NEW MEMBER ☐ CHANGE OF COVERAGE
☐ CHANGE OF SUBSCRIBER OR DEPENDENT INFORMATION ☐ RE-ENROLLMENT ☐ TERMINATION OF DEPENDENT

2. SUBSCRIBER INFORMATION (YOUR EMPLOYER WILL COMPLETE THE 4 SHADED BOXES IN THIS SECTION.)

Last Name / First Name / MI		Social Security/Membership No.	Group Number __ __ __ __
Street Address	Apt. No.	Employment Date	Department Number __ __ __ __ __ __ __ __ __ __
City / State / Zip		Employment Status ☐ Active ☐ Retired	Effective Date __ __ / __ __ / __ __ __ __
Sex ☐ M ☐ F	Date of Birth / Home Phone Number	Business Phone Number Ext.	Employee/Payroll Number __ __ __ __ __ __
Subscriber's Marital Status ☐ Single ☐ Married	Date of Marriage	Name of Employer	

3. MEDICARE AND TERFA INFORMATION

If Eligible for Medicare: *Claim No.* *Hospital Insurance Effective Date* *Hospital Insurance Effective Date* *Medical Insurance*

If actively employed and TEFRA applicable, complete primary carrier selection. *Subscriber:* Blue Cross ☐ or Medicare ☐ *Spouse:* Blue Cross ☐ or Medicare ☐

4. OTHER HEALTH INSURANCE INFORMATION – (WE REQUIRE THE INFORMATION REQUESTED IN THIS SECTION.)

Do you or your dependents have any other health insurance policy or Blue Cross/Blue Shield other than through your employer? ☐ Yes ☐ No

Name of Spouse's Employer:

If yes, Name of Person Covered

Name of Insurance Company:

Date of Birth: City: State:

Name of Employer: Policy or Certificate No.:

If covered by Maryland or other Blue Cross/Blue Shield Plan:
Membership No.: *City:* *State:*

5. COVERAGE LEVEL SELECTION

Check coverage level desired ☐ Individual ☐ Husband & Wife ☐ Parent & Child ☐ Family

6. GENERAL DEPENDENT INFORMATION

Add or Change A or C	If the **LAST NAME** of a child is **DIFFERENT,** check the "Sole Support" column to indicate that you provide the sole support for the minor dependent. Dependents	Last Name	First	M.I.	Sole Support	SEX	REL	Date of Birth	Social Security Number
	Spouse				☐		SP		
	Child				☐		CH		
	Child				☐		CH		
	Child				☐		CH		
	Child				☐		CH		
	Child				☐		CH		
	Child				☐		CH		

7. DETAILED DEPENDENT INFORMATION – ARE ANY OF YOUR DEPENDENTS:

Covered by Medicare? ☐ No ☐ Yes *Name:* Medicare No.:

Handicapped? No ☐ Yes ☐ *Name:* *Effective Date*

Name: *Effective Date*

Full time college student? No ☐ Yes ☐
Name: *School Name:*
Name: *School Name:*

8. TERMINATION OF DEPENDENTS

Do NOT use this section to change coverage level.
See Instructions: Dependent Termination Only.

Name	Date of Reason	*Write Correct Reason Code* Reason
Name	Date of Reason	Reason

Reason Codes
1. Divorce 2. Death 3. Entered Military
4. Child reached eligibility age limit 5. Other

READ CAREFULLY. THIS APPLICATION, WHEN ACCEPTED, IS PART OF THE CONTRACT.

I hereby apply, on behalf of myself and each dependent listed above, for the health coverage indicated. If this application is accepted, coverage will be provided according to the terms and conditions of the health care contract between CareFirst BlueCross BlueShield and my employer. I agree to be bound by that health care contract and to pay current and future charges for the health coverage provided. My employer is authorized to deduct the appropriate amount for such chargers from my pay for that purpose.

I hereby authorize any physician, hospital, or other provider of service to furnish any information, reports, records, or copies of records, relating to care or services rendered to me or any of the dependents listed above to, CareFirst BlueCross BlueShield. Such information is to be held confidential.

I have carefully read this application and agree to its terms. The information provided is true and complete and is submitted in order to cause the issuance of the health coverage selected.

THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE ANY SECTION MAY DELAY CLAIMS PAYMENT.

EMPLOYEE'S SIGNATURE (Subscriber) DATE

SPOUSE'S SIGNATURE (Required for TEFRA) DATE

REMOVE PAGE 1 & 2, ATTACH TO A TRANSMITTAL (UNT0003-1S OR UNT0005-1S), THEN FORWARDED ALL TO CAREFIRST BLUECROSS BLUESHIELD OR YOUR ADMINISTRATOR.

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