CareFirst BlueCross BlueShield

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

Enrollment Form

(Virginia Groups)

HOW TO COMPLETE THIS FORM:

1. Please type or print clearly with pen.
2. Complete all appropriate items, sign and date.
3. Please return this form to your employer.
4. **Employer must complete if Section VII is answered** – Number of employees in group: _____.

I. EMPLOYER INFORMATION – To be completed by the employer

Employer / Group Administrator	Effective Date Requested	Group Number
Meritek, Inc.	/ /	14MJ

II. ENROLLEE

Social Security Number	Date of Birth	Sex
	/ /	☐ Male ☐ Female

Last Name | First Name | Middle Initial

Date of Hire	Occupation	Employment Status
/ /		☐ Full-Time ☐ Part-Time ☐ Retired

Residence Address *(Number and Street)* | *(City and State)* | *(Zip Code – 9-digit, if known)*

Home Phone	Work Phone	Marital Status
( )	( )	☐ Single ☐ Married ☐ Domestic Partner ☐ Other ☐ Separated ☐ Divorced

III. TYPE OF ENROLLMENT

CHECK ONE: ☐ New ☐ Coverage Change

IV. TYPE OF COVERAGE

To avoid delays in processing this form, please confirm with your employer the details of the benefit options and coverage levels offered by your employer prior to completing this section.

CHECK ONE:
- ☐ Individual
- ☐ Individual and Adult
- ☐ Individual and Child
- ☐ Individual and Children
- ☐ Family
- ☐ Coverage Complementary to Medicare (Individual only and benefit coverage only; not eligible for HSA)

IF ENROLLING FOR MEDICAL COVERAGE, CHECK ONE:
- ☐ BluePreferred, Option 1 ☐ Option 19
- ☐ BlueFund BluePreferred HRA, Option _____
- ☐ BlueFund BluePreferred HSA, Option _____
- ☐ BluePreferred HRA Compatible, Option _____
- ☐ BluePreferred HSA Compatible, Option 6
- ☐ Other

CHECK ALL APPLICABLE:
- ☐ Preferred Dental
- ☐ Traditional Dental
- ☐ BlueVision *Plus*

V. CHANGE TO EXISTING ENROLLMENT

Dependents affected by additions or deletions must be listed in Section VI - Dependent Information.

Identification Number, if different from Social Security Number: _____

- ☐ ADD dependent(s) listed in Section VI
- ☐ ADD spouse due to marriage on _____ (Date)
- ☐ ADD domestic partner on _____ (Date)
- ☐ ADD child due to adoption on _____ (Date) or appointed legal guardian by court decree dated _____

  (Note: Documentation of adoption or court-appointed legal guardianship must be provided)
- ☐ REMOVE dependent(s) listed in Section VI due to _____ (Reason) on _____ (Date)
- ☐ CHANGE address to that shown in Section II
- ☐ CHANGE my name from _____ to that shown in Section II

VI. DEPENDENT INFORMATION

1	**Spouse**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	
2	**Domestic Partner**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	
3	**Child**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	
4	**Child**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	
5	**Child**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	
6	**Child**	Name – (Last, First, MI)	Coverage Level ☐ Medical ☐ Dental ☐ BlueVision *Plus*	Social Security Number
		Date of Birth / /	Sex ☐ Male ☐ Female	

COMPLETE ONLY IF CHILD IS A STUDENT OR DISABLED (AGE 26 OR OLDER)

If child is a student age 26 or older, please confirm coverage with your employer prior to completing this section.

Child Name – (Last, First, MI)	Full-Time Student? ☐ Yes ☐ No	**If Yes, Attach Student Certification Form**	Disabled? ☐ Yes ☐ No	**If Yes, Attach Disability Certification Form and Supporting Documentation**
Child Name – (Last, First, MI)	Full-Time Student? ☐ Yes ☐ No		Disabled? ☐ Yes ☐ No	

VII. MEDICARE COVERAGE

FAILURE TO COMPLETE THIS SECTION, IF APPLICABLE, WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

☐ Check this box if any person listed on this form is eligible for or receiving benefits under Medicare.

If you checked the box, 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 ___ /___ /___

EMPLOYMENT STATUS (CHECK ONLY ONE BOX): ☐ Actively Employed ☐ Retired

Name _____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled

Medicare Claim No. _____ Eligible for: ☐ Part A Eff. Date ___ /___ /___ ☐ Part B Eff. Date ___ /___ /___

EMPLOYMENT STATUS (CHECK ONLY ONE BOX): ☐ Actively Employed ☐ Retired

VIII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT CLAIMS PROCESSING DELAYS.

☐ Check this box 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, another insurance carrier, or Medicaid. 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 and Social Security Number _____
   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 _____ /_____ /_____
   month day year
5. Service(s) Covered:

A. Hospital Services	☐ Yes ☐ No	E. Dental	☐ Yes ☐ No
B. Physician Services	☐ Yes ☐ No	F. Eye / Vision Care Services	☐ Yes ☐ No
C. Major Medical (out-of-pocket expenses)	☐ Yes ☐ No	G. Mental Illness Services	☐ Yes ☐ No
D. Separate Drug Program	☐ Yes ☐ No	H. HMO	☐ Yes ☐ 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
8. To be completed if the parents live apart and provide medical coverage for their child(ren):
   Please indicate relationship to child(ren).

PARENT WITH COURT-ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES	_____ *Parent's Name / Relationship*	PARENT WITH CUSTODY OF CHILD(REN)	_____ *Parent's Name / Relationship*
	_____ *Child's Name / Date of Birth*		_____ *Child's Name / Date of Birth*

IX. PLEASE READ CAREFULLY – THIS SECTION MUST BE DATED AND SIGNED

I hereby enroll, on behalf of myself and each dependent listed above, for the coverage indicated. Coverage will be provided according to the terms and conditions of the contract between CareFirst BlueCross BlueShield 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 charges to my employer.

CareFirst BlueCross BlueShield may rescind or void my coverage only if (1) I have performed an act, practice, or omission that constitutes fraud; or (2) I have made an intentional misrepresentation of material fact. CareFirst BlueCross BlueShield will provide 30-days advance written notice of any rescission of coverage and refund any paid premiums to the group.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia state law.

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.

_____

Enrollee Signature Date

X. CONSENT TO RECEIVE ELECTRONIC NOTICES

CareFirst BlueCross BlueShield wants to help you manage your health care information and protect the environment by offering you the option of electronic communication.

Instead of paper delivery, you can receive electronic notices about your CareFirst BlueCross BlueShield health care coverage through email and/or text messaging by providing your email address and/or cell phone number and consent below.

Electronic notices regarding your CareFirst BlueCross BlueShield health care coverage include, but are not limited to:

- Explanation of Benefits alerts
- Reminders
- Notice of HIPAA Privacy Practices
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

Please note, you may change your email, cell phone and consent information anytime by logging into www.carefirst.com/myaccount or by calling the customer service phone number on your ID card. You can also request a paper copy of electronic notices at any time by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically through email, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

I understand that to receive notices through text messaging:

- A text messaging plan with my cell phone provider is required; and
- Standard text messaging rates will apply.

By checking below, I hereby agree to electronic delivery of notices, instead of paper delivery, by:

- ☐ Email only
- ☐ Cell phone text messaging only
- ☐ Email and cell phone text messaging

By signing below, I hereby agree to electronic delivery of notices.

Member Name	Signature	Email Address	Cell Phone Number

By signing below, my spouse/partner and any other dependents covered by CareFirst BlueCross BlueShield individually agree to electronic delivery of notices.

Spouse/Partner/ Dependent Name	Signature	Email Address	Cell Phone Number

CareFirst BlueCross BlueShield will not sell your email address or cell phone number to any third party and we do not share them with third parties except for CareFirst BlueCross BlueShield vendors that perform functions on our behalf or to comply with the law.

XI. RACE, ETHNICITY, LANGUAGE (This information is voluntary.)

CareFirst BlueCross BlueShield is asking its members to voluntarily provide their race, ethnicity, and language attributes. The information provided, while voluntary, will assist us to improve quality of care and access to care, thereby reducing health care disparities and promoting better health outcomes. The information you provide will not have a negative impact on any services we provide to you. The information is kept strictly confidential and will not be shared unless we are required by law to disclose it.

Race
White/Caucasian
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Other – (To include Multi-Racial)
Decline to answer
Unknown – Could not be determined

Ethnicity
Hispanic/Latino/Spanish origin

Preferred Spoken Language*
01 English
02 Albanian
03 Amharic
04 Arabic
05 Burmese
06 Cantonese
07 Chinese (simplified & traditional)
08 Creole (Haitian)
09 Farsi
10 French (European)
11 Greek
12 Gujarati
13 Hindi
14 Italian
15 Korean
16 Mandarin
17 Portuguese (Brazilian)
18 Russian
19 Serbian
20 Somali
21 Spanish (Latin America)
22 Tagalog (Filipino)
23 Urdu
24 Vietnamese
98 Other and unspecified languages
99 Unknown

Last Name		First Name	Race	Ethnicity	Country of Origin	Preferred Spoken Language (*specify number from above)
Enrollee						
Spouse						
Domestic Partner						
Child						
Child						
Child						
Child						

Enrollee Signature _____ Date