Individual BluePreferred-Saver Application

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

(District of Columbia Residents)

ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. 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 Subscriber)

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	Marital Status	Height	Weight
/ /	☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner		
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 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	HT (in.)	WT (lbs.)
Spouse/Domestic Partner							☐M ☐F		
Dependent 1							☐M ☐F		
Dependent 2							☐M ☐F		
Dependent 3							☐M ☐F		
Dependent 4							☐M ☐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 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.

4. COVERAGE LEVEL:

CHECK ONE:	Individual Deductible (In-Network)	Individual Deductible (Out-of-Network)	Coverage Level (In-Network)	Coverage Level (Out-of-Network)	Individual Out-of-Pocket Limit (In-Network)	Individual Out-of-Pocket Limit (Out-of-Network)
☐	$2,500	$5,000	70%	60%	$5,000	$10,000
☐	$5,000	$10,000	100%	80%	$5,000	$12,500
☐	$10,000	$12,500	100%	80%	$10,000	$15,000

MATERNITY BENEFITS: Check this box if you wish to include benefits for maternity 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? .... ☐ ☐

   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? . ☐ ☐

   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? .... ☐ ☐

3. Has anyone listed on this application been without health insurance for the past 12 months or longer? .... ☐ ☐

   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? ..... ☐ ☐

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 or 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)	☐	☐
2.	Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test)	☐	☐
3.	Kidney stones, kidney or bladder condition, urinary frequency or burning	☐	☐
4.	Goiter, thyroid condition, diabetes	☐	☐
5.	Seizure disorder, central nervous system disorder, multiple sclerosis	☐	☐
6.	Substance abuse (drug or alcohol dependency, abuse or addiction)	☐	☐
7.	Use of illicit drugs	☐	☐
8.	Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	☐	☐
9.	Cataract or other eye condition	☐	☐
10.	Tuberculosis, lung condition, asthma, bronchitis	☐	☐
11.	Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	☐	☐
12.	Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke)	☐	☐
13.	(Female) Irregular or excessive menstrual bleeding, reproductive system disorders, breast condition	☐	☐
14.	(Female) Is currently pregnant; expected date of delivery: _____/_____/_____	☐	☐
15.	(Male) Prostate condition, reproductive system disorders	☐	☐
16.	Do you or your spouse/partner have infertility or any disorder related to infertility	☐	☐
17.	Have you or your spouse/partner received any treatment or diagnostic “work-up” related to infertility	☐	☐
18.	Have you been told that you have high or elevated cholesterol, lipids or triglycerides	☐	☐
19.	Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	☐	☐
20.	Sexually transmitted diseases	☐	☐
21.	Anemia, blood disorders	☐	☐
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?	☐	☐
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?	☐	☐

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

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

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.

Patient’s 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:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL
			FROM: TO:		☐ FULL ☐ PARTIAL

(over, please)

7. 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, from Group Hospitalization and Medical Services, Inc. doing business as 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 Group Hospitalization and Medical Services, 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's 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 a 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 occur prior to acceptance of this application by CareFirst.

By signing this application, I hereby authorize CareFirst BlueCross BlueShield to disseminate and share non-health questionnaire information contained on this application with the Health Savings Account preferred bank(s) affiliated with CareFirst BlueCross BlueShield. I understand that dissemination of information to any such bank is at my direction and with my full understanding. Further that dissemination of information on this application, excluding health questionnaire information, is necessary in order to effectuate the establishment of a Health Savings Account in my name with the bank. The authorization shall continue until my enrollment with CareFirst BlueCross BlueShield terminates or at any time that I provide a written instruction to CareFirst BlueCross BlueShield revoking this authorization or if this authorization terminates by operation of law.

If you do not want information on this application shared with the Health Savings Account preferred bank(s) please check here. ☐

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 BlueCross BlueShield due to medical underwriting may not submit a subsequent application for enrollment within ninety (90) days of the denial.

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, CareFirst may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signature of Applicant 1:* X______________________________ Date:____________________

Signature of Applicant 2: X______________________________ Date:____________________
(Spouse/Partner)

*Rates are based on the age of the Subscriber (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)

BluePreferred-Saver

Leaving more money in your hands

You're active.
You're healthy.
You *still* need health insurance.

Health Care Coverage for residents of Washington, DC who buy their own health insurance.

Questions? Call 1-877-634-1256

Leaving more money in your hands

BluePreferred-Saver is a product for people like you:

people who know they need health coverage, but don't want to spend a lot of money for it. ***With BluePreferred-Saver's design, you save money, even if you don't visit the doctor very often.***

- **Save with lower monthly premiums**, and rest assured: you're covered for life's sudden health emergencies.
- **Save at the doctor's office**. Your expense is limited to a small copay for the first two visits each year (excluding preventive care). All of your preventive care visits in-network are covered with a small copay and no deductible.
- **Save on prescription drugs**. After meeting a lower deductible, you pay only a $15 copay for generic drugs, and get discounts on brand name prescriptions.

Save your hard-earned money, in the event of a medical emergency, and let CareFirst BlueCross BlueShield (CareFirst) cover you. With BluePreferred-Saver, you know what your maximum out-of-pocket expenses will be in any given year. Once you reach the out-of-pocket maximum, CareFirst pays 100% of your covered medical expenses (excluding prescriptions) for that benefit year. And, you can rest assured knowing that your BluePreferred-Saver coverage has a substantial $3,000,000 lifetime benefit maximum for covered medical services.

A health plan that actually gives you opportunities to save while keeping you covered, at a competitive price.

Individuals under the age of 30 can get coverage for less than $100 a month! Choose a plan with a higher deductible, and you'll pay even less for your coverage.

As a member, you'll get built-in cost savings from one of the region's leading health insurers, CareFirst BlueCross BlueShield. And, you'll be able to count on the negotiating power of CareFirst, by receiving discounts on medical care, prescriptions and a host of other programs designed to help you maintain your good health.

- **Save more by using in-network doctors.**
  You can see any doctor you like. However, you'll notice significant savings when you use doctors within CareFirst's Preferred Provider Network, which includes more than 24,000 providers and 42 hospitals locally.

- **Save time by avoiding cumbersome paperwork.**
  You won't need referrals. And you'll have few, if any, claim forms.

- **Save with discounts on health-related programs.**
  As a CareFirst member, you are entitled to discounts on alternative therapies and health and wellness programs such as chiropractic, acupuncture, massage, yoga, Pilates, tai chi, qi gong, guided imagery and fitness centers. Also, this program offers discounts on Weight Watchers® Online and Jenny Craig®, mail order contacts, laser-vision correction, hearing aids, and eldercare management. Since this program is *in addition to* your medical plan rather than a benefit, there are no claim forms, paperwork or referrals.

Leaving more money in your hands

Choose the deductible level right for you

With BluePreferred-Saver, you have three plans to choose from. The choice is yours. The higher your deductible, the lower your premium and member coinsurance. Tailor your coverage to your budget.

Option 1: $2,500 Deductible

	In-Network		Out-of-Network	
Deductible	Individual:	$2,500	Individual:	$5,000
	Family:	$5,000	Family:	$10,000
Member Coinsurance	30%		40%	
Out-of-Pocket Maximum	Individual:	$5,000	Individual:	$10,000
	Family:	$10,000	Family:	$20,000

Option 2: $5,000 Deductible

	In-Network		Out-of-Network	
Deductible	Individual:	$5,000	Individual:	$10,000
	Family:	$10,000	Family:	$20,000
Member Coinsurance	0%		20%	
Out-of-Pocket Maximum	Individual:	$5,000	Individual:	$12,500
	Family:	$10,000	Family:	$22,500

Option 3: $10,000 Deductible

	In-Network		Out-of-Network	
Deductible	Individual:	$10,000	Individual:	$12,500
	Family:	$20,000	Family:	$25,000
Member Coinsurance	0%		20%	
Out-of-Pocket Maximum	Individual:	$10,000	Individual:	$15,000
	Family:	$20,000	Family:	$27,500

All three BluePreferred-Saver plans give you the security and peace of mind of a substantial $3,000,000 lifetime policy maximum.

How the Plan Works:

- You pay up to the deductible, when applicable. Families never pay more than two times the individual deductible in a benefit year. Remember, for just a $30 copay per visit, your first two in-network office visits (excluding preventive care) are covered.
- Once the deductible has been met, BluePreferred-Saver pays a percentage (100% or 70% for in-network providers) of the allowed amount. This is called the coverage level. The percentage that you pay (0% or 30% for in-network providers) is referred to as coinsurance.
- Unlike many other plans, your deductible and most coinsurance payments are included as part of your out-of-pocket maximum, which is the maximum an individual on your policy spends toward coinsurance and deductibles per year.
- Once your out-of-pocket maximum is reached, no further coinsurance or deductibles will be required in that calendar year.*
- Eligible expenses of all covered members can be combined to satisfy the family out-of-pocket limit. An individual family member cannot contribute more than the individual out-of-pocket limit toward meeting the family out-of-pocket limit.

**Please note that the prescription program deductible, copayments and maximums are separate from the medical deductible, copayments and maximums.*

Leaving more money in your hands

In-Network Benefits at a Glance

Medical Benefits	You Pay (In-Network)
Lifetime Maximum	$3 million
Preventive Services	
Routine Adult Physical	$30 per visit (no deductible)
Well-Child Care Including Exams and Immunizations	No charge
Routine OB/GYN Visits	$30 per visit (no deductible)
PAP test, Mammograms, Prostate Screening & Colorectal Screening	No charge
Office Visits, Labs and Testing	
Office Visits (excluding preventive care) 1-2 visits 3+ visits	 $30 per visit (no deductible) Deductible & Coinsurance
X-ray and Lab Tests	Deductible & Coinsurance
Allergy Treatments	Deductible & Coinsurance
Emergency Care	
Emergency Room	Deductible & Coinsurance
Urgent Care Center	Deductible & Coinsurance
Ambulance (when medically necessary)	Deductible & Coinsurance
Hospitalization	
Inpatient Facility Services	Deductible & Coinsurance
Inpatient Physician Services	Deductible & Coinsurance
Outpatient Facility Services	Deductible & Coinsurance
Outpatient Physician Services	Deductible & Coinsurance
Vision Services	
Routine Annual Exam (administered by Davis Vision)	$10
Prescription Drug Benefits	
Deductible	$150
Generic Copay	$15
Preferred Brand Copay	Discount
Non-Preferred Brand Copay	Discount
Annual Maximum (per person)	$1,500 (generic drugs)

Care received out-of-network is subject to higher deductibles and coinsurance. There is a 10-month waiting period for coverage on pre-existing conditions.

Optional Extended Maternity Services may be added for you or your covered spouse or domestic partner. For an additional $126 a month, you'll receive coverage of up to $3,000 per pregnancy for covered pre- and postnatal care as well as covered services associated with the delivery. If you add maternity coverage at any time following your initial enrollment in BluePreferred-Saver, there will be a 10-month waiting period for maternity benefits.

It's easy to apply

To be eligible for BluePreferred-Saver coverage, each family member applying must be a resident of Washington, DC and complete a medical questionnaire.

Just follow these easy steps to apply.

1. Choose what type of coverage you need. You can select:
   - Individual
   - Individual and Child(ren)*
   - Individual and Adult**
   - Family [Two eligible adults and eligible dependent(s)]

   *"Child" means your unmarried, *eligible* child up to age 23. Eligibility requirements are defined in the BluePreferred contract.

   **"Adult" means the spouse of the subscriber or the domestic partner of the Subscriber who resides with the subscriber and satisfies the eligibility requirements defined in the BluePreferred contract. The subscriber and domestic partner may not share a blood or familial relationship, and must have shared a common legal residence continuously for at least six (6) months prior to applying for coverage.

   If you have questions about eligibility, please call our Product Specialists at 1-877-634-1256

2. Choose the plan that best fits your needs. The enclosed rate charts for each plan, coverage type, and age will help you identify your monthly premium.

3. Locate the application form in this packet. Be sure to answer all questions honestly and completely, and don't forget to sign your application. Make sure you check "yes" in the Maternity benefit selection area, if you wish to elect optional extended maternity benefits.

4. Mail your application in the enclosed envelope. Send no money at this time. We'll begin processing your application right away! The review process takes about 4-6 weeks. Once you have submitted your application, you can call the Application Status Hotline at 1-877-634-1256 with questions. Your coverage will become effective the first of the month following the month in which we approve your application. Once effective, you'll receive your ID cards and everything else you need.

Additional Coverage Options

- **BluePreferred** and BluePreferred HSA**** – A Preferred Provider Organization that reduces your out-of-pocket costs with lower deductible plans including health savings account-compatible plans.
- **Supplement-65** – Traditional coverage to supplement your Medicare policy. For more information about this plan, please call our Product Specialists toll free 1-877-634-1256

Other Coverage Options:

- **CareFirst BlueChoice**, BlueChoice-Saver** & BlueChoice-HSA**** – A flexible HMO plan, offered by CareFirst BlueChoice, Inc., an affiliate, including low-premium and health savings account-compatible plans.

** *Medical questionnaire must be completed.*

Policy Form Numbers
DC/CF/LCRX (1/05) • DC/CF/LC70 (1/05) • DC/CF/LC100 (1/05) • DC/DP-1EA (9/95) • PPP-A/DC (4/96) • DC/C-DP (4/96) and any amendments

Not all services and procedures are covered by your benefits contract.
This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc.
CareFirst BlueChoice, Inc. and CareFirst BlueCross BlueShield are independent licensees of the
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®′ Registered trademark of CareFirst of Maryland, Inc.

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