

Attached is your Maryland Health Insurance application  
from TheInsuranceNet.com

Steps to complete CareFirst Maryland Health Insurance HIPAA application.

- 1) Print out the attached application.
- 2) Complete application including ALL details and signatures.  
Common mistakes that delay the start of application processing are missing information.  
Return with "Certificate of Credible Coverage" from COBRA plan.
- 3) Return application without payment. If you're approved  
CareFirst Blue Cross will send you billing information.
- 4) FAX direct to 1-877-877-5801 or Mail all materials to:  
TheInsuranceNet.com  
Attn: CareFirst Blue Cross Blue Shield  
5965 Sandy Ridge  
Elkridge, MD 21075
- 5) Call with any questions.

1-877-634-1256

TheInsuranceNet.com

*“Using technology to provide you with information  
& people to provide you with answers.”<sup>SM</sup>*

\*rates subject to change without notice.

Please note that underwriting can take 4-6 weeks (less for healthy applicants with complete applications). You are NOT covered until accepted by Carefirst. During the underwriting period, DON'T cancel any existing coverage. If you don't have coverage you can apply for a temporary health insurance policy to cover you in the interim from our web site <http://www.theinsurancenet.com>. Temporary Health Insurance can start as early as tomorrow. Select a monthly payment, so you can keep it during the underwriting process.

# Personal Comp HIPAA Application

(Maryland Residents)



10455 Mill Run Circle  
Owings Mills, Maryland 21117

<b>CONTRACT CODE</b>	<b>MEMB. NO.</b>	<b>Eff. Date</b>	<b>DV</b>
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Please do not remove this mailing label. We need this information to make certain that your name is correctly maintained in our files. Thank you.

FAX COMPLETED APPLICATION TO 1-877-877-5801  
OR MAIL TO: 5965 Sandy Ridge, Elkridge, MD 21075

## 1. 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.
3. SEND NO MONEY WITH THIS APPLICATION. You will be notified by mail of the amount due if this application is accepted. No salesperson will call you.

GIVE CAREFUL ATTENTION TO ALL QUESTIONS IN THIS APPLICATION. ACCURATE COMPLETE INFORMATION, AS REQUESTED, IS NECESSARY BEFORE YOUR APPLICATION CAN BE PROCESSED. IF INCOMPLETE, THE APPLICATION WILL BE RETURNED AND DELAY YOUR COVERAGE.

## 2. APPLICANT INFORMATION

**NOTE: All applicants must be listed below. The oldest applicant will be the policyholder.**

LAST NAME	FIRST NAME AND MIDDLE INITIAL	RELATIONSHIP	DATE OF BIRTH			SOCIAL SECURITY NUMBER
			Month	Day	Year	
		Policyholder M <input type="checkbox"/> F <input type="checkbox"/>				
		Spouse M <input type="checkbox"/> F <input type="checkbox"/>				
		Son <input type="checkbox"/> Daughter <input type="checkbox"/>				
		Son <input type="checkbox"/> Daughter <input type="checkbox"/>				
		Son <input type="checkbox"/> Daughter <input type="checkbox"/>				
		Son <input type="checkbox"/> Daughter <input type="checkbox"/>				
		Son <input type="checkbox"/> Daughter <input type="checkbox"/>				
		Son <input type="checkbox"/> Daughter <input type="checkbox"/>				

Address \_\_\_\_\_ (Number) \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (ZIP)

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Date of Marriage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Area Code Area Code (If applicable) (Month) (Day) (Year)

E-mail Address \_\_\_\_\_  
 Policyholder's Employer \_\_\_\_\_ Self-Employed? Yes  No  Occupation \_\_\_\_\_ Full-time  Part-time   
 Spouse's Employer \_\_\_\_\_ Self-Employed? Yes  No  Occupation \_\_\_\_\_ Full-time  Part-time

## 3. PROGRAM SELECTION

On behalf of myself as applicant and the other members of my family whose names appear on this application, I hereby apply for coverage as selected below.

A. Select Deductible Level (check one)  \$400  \$800

B.  Add Dental Coverage

C.  Add Vision Coverage

FOR BROKER USE ONLY:	<b>Name:</b> Kelly & Assoc. Ins. Grp. #132	<b>SSN/Tax ID #:</b> 52-1066374	<b>CareFirst-Assigned ID#:</b>
<b>Contracted Broker:</b>	J. MOTSCO		
<b>Sub-Agent/Sub-Agency:</b>	J. MOTSCO		
<b>Writing Agent:</b>	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 SELECTION

- INDIVIDUAL** - Provides coverage for one person.
- HUSBAND & WIFE** - Provides coverage for a husband and wife only.
- PARENT & CHILD** - Provides coverage for one parent and one eligible dependent.
- FAMILY** - Provides coverage for a husband, wife and eligible dependent(s) or one parent with more than one eligible dependent.

#### 5. OTHER INSURANCE INFORMATION

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 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

#### 6. CREDITABLE COVERAGE INFORMATION

1. Is any applicant eligible for coverage under any group health benefits plan or employer sponsored health benefits plan?  Yes  No  
If yes, please state the name of the applicant(s) \_\_\_\_\_
2. Is any applicant eligible or entitled to Medicare, Part A or Part B?  Yes  No  
If entitled, please state the name of the applicant(s) \_\_\_\_\_  
and the applicant's Medicare Number(s) \_\_\_\_\_
3. Is any applicant eligible for Medicaid, or any similar state plan under Title XIX of the Social Security Act?  Yes  No  
If yes, please state the name of the applicant(s) \_\_\_\_\_
4. Is any applicant currently covered under any other health benefit plan?  Yes  No  
If yes, please state the name of the applicant(s) \_\_\_\_\_  
the date of birth of the applicant(s) \_\_\_\_\_  
the name and address of the insurer or health plan(s) \_\_\_\_\_  
\_\_\_\_\_  
the policy or group number(s) \_\_\_\_\_  
the applicant's identification number(s) \_\_\_\_\_
5. Was any applicant's prior health benefits plan terminated because of nonpayment of the premium or subscription charges by the applicant when due?  Yes  No  
If yes, please state the name of the applicant(s) \_\_\_\_\_
6. Was any applicant's prior health benefits plan terminated for reasons of a fraudulent act by the applicant?  Yes  No  
If yes, please state the name of the applicant(s) \_\_\_\_\_

Federal law requires that a group health plan sponsored by an employer who regularly employs 20 or more employees offer employees and their families the opportunity for a temporary extension of health coverage called **Continuation Coverage (or COBRA coverage)**. This Continuation Coverage is offered for a specific number of months depending on the applicant's situation. The employer or Plan Administrator will be able to tell an applicant how many months of Continuation Coverage is available.

## 6. CREDITABLE COVERAGE INFORMATION (CONTINUED)

7. If any applicant was offered this Continuation Coverage, did that applicant refuse this coverage or elect to terminate this coverage before the end of the allowed Continuation Coverage period?  Yes  No  
If yes, please state the name of the applicant(s) \_\_\_\_\_
8. During the past 18 months has any applicant lost coverage under any health benefits plan for a period of 63 consecutive days or more?  Yes  No

If you have answered NO to all of the questions above, then under State and Federal law you are eligible for this coverage without medical underwriting, and Section III. of the Policy, Pre-Existing Conditions, and all waiting periods described in the Policy, will not be applied to your benefits.

**NOTE:** An applicant's prior insurer or health plan, if any, is required by federal law to provide a Certificate of Coverage that indicates how many months the applicant has been continuously covered under "creditable coverage", as defined under federal law. **Please attach all Certificates of Coverage to this application.** Retain a copy for your records.

An applicant who cannot obtain a Certificate of Coverage can provide written documentation from an employer or health plan showing creditable coverage. Such applicants are encouraged to call CareFirst BlueCross BlueShield prior to submitting this additional information with this application.

## 7. CONDITIONS OF ENROLLMENT

I hereby apply for myself and on behalf of my spouse and dependents (if listed on this application) for a CareFirst BlueCross BlueShield policy.

### I AGREE TO THE FOLLOWING:

1. I have the authority to act for myself, my spouse and all of my dependents including those who have reached the age of majority.
2. The policy will be effective only if accepted and only for those insureds accepted by CareFirst BlueCross BlueShield.
3. If accepted, a policy will be issued stating the benefits to which insureds are entitled and the conditions under which benefits will be available, together with an identification card showing the effective date of the policy.
4. The policy, application and any attached endorsements shall constitute the entire agreement and supersede any previous agreements.
5. I will pay the premium charges to CareFirst BlueCross BlueShield when due.
6. In the event there is an error made in any payment of benefits, I agree to remit CareFirst BlueCross BlueShield the amount of any overpayment of benefits to which I am not entitled.

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 BlueCross BlueShield policy. Failure to provide complete and accurate information on this application may result in voiding any policy issued on the inaccurate information.

I have carefully read this application and agree to the terms specified thereon.

Date \_\_\_\_\_

\_\_\_\_\_  
Policyholder Signature (DO NOT PRINT)

\_\_\_\_\_  
Spouse's Signature (DO NOT PRINT)

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

Date \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian's Signature

## HIPAA Monthly Premium Rates\*

effective 1-1-04 and subject to change

### PERSONAL COMP \$400

Age	Individual	Parent/Child	Husband/Wife	Family
1-5	\$146	N/A	N/A	N/A
6-17	\$130	N/A	N/A	N/A
18-29	\$210	\$314	\$420	\$546
30-39	\$258	\$386	\$514	\$670
40-49	\$318	\$476	\$636	\$826
50-59	\$406	\$610	\$814	\$1,058
60-64	\$492	\$738	\$986	\$1,280

### PERSONAL COMP \$800

Age	Individual	Parent/Child	Husband/Wife	Family
1-5	\$114	N/A	N/A	N/A
6-17	\$102	N/A	N/A	N/A
18-29	\$164	\$246	\$328	\$428
30-39	\$202	\$302	\$404	\$524
40-49	\$250	\$374	\$498	\$648
50-59	\$318	\$478	\$638	\$830
60-64	\$386	\$580	\$772	\$1,004

### Dental And Vision

	Individual	Parent/Child	Husband/Wife	Family
Dental	\$10.94	\$17.49	\$21.88	\$29.77
Vision	\$2.00	\$3.25	\$4.00	\$5.00
Dental & Vision	\$12.94	\$20.74	\$25.88	\$34.77