

The following pages are your Virginia **BlueCross BlueShield Health Insurance Application**  
from RxMom.com



Please follow these steps to complete

- 1. Print the Application below
- 2. Fill out the Forms Completely. Please include all details and remember to sign the application.
- 3. **Fax (866)707-9532** or Mail the entire application form to:

**BlueCross by RxMom.com**  
**P O Box 488**  
**Laurel, MD 20725**

Please **DO NOT** send any payment. If your application is approved  
CareFirst BlueCross Blue Shield will bill you directly

You may additionally choose to enroll for the **AUTOMATIC DEBIT PLAN** by completing the  
Authorization form (Please Remember to Attach a Voided Check) **MAIL IN ONLY**

PLEASE CALL US AT **(888)490-8782** If you have any questions

**IMPORTANT**

\*Rates subject to change without notice.

-This is an application for an underwritten plan. Underwriting can take between 4-6 weeks ( This can be considerably shorter for a healthy applicant with a complete application)

-You do NOT have coverage until your application is accepted by CareFirst BlueCross BlueShield

-Please do NOT cancel any existing coverage during the underwriting process

-If you do not have any coverage you may apply for temporary or **Short Term health Insurance at RxMom.com**

-Short term Insurance can start as early as tomorrow thus you can use it during the underwriting process.

# Individual CareFirst BlueChoice, Inc. HSA Application



(Virginia Residents)

OFFICE USE ONLY:

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

CareFirst BlueChoice, Inc.  
840 First Street, NE, Washington, DC 20065

## INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Be sure to select a **Primary Care Physician (PCP) and PCP ID number** for all enrolled applicants.
3. Sign and return this application in the postage-paid return envelope if provided, or mail to CareFirst BlueCross BlueShield, Individual Market Division/ RR-291, 10455 Mill Run Circle, Owings Mills, MD 21117-9685.

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 Application to (866)707-9535  
 or  
 Mail Application To:  
**RxMom.com -BlueCross Processing**  
**P O Box 488**  
**Laurel MD 20725**

## 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, 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		
Name of Primary Care Physician (PCP)				PCP ID Number	

## 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)

COVERAGE LEVEL DESIRED:	PCP/Specialist		Prescription Drug	
CHECK ONE:	Deductible	Copay	Out-of-Pocket Max	(after deductible)
<input type="checkbox"/>	\$1,200 (Individual) / \$2,400 (Family)	\$30 / \$40	\$2,400 (Individual) / \$4,800 (Family)	\$5 / \$25 / \$45
<input type="checkbox"/>	\$2,700 (Individual) / \$5,400 (Family)	\$30 / \$40	\$5,250 (Individual) / \$10,500 (Family)	\$5 / \$25 / \$45

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

FOR BROKER USE ONLY:	Name	SSN/Tax ID #	CareFirst-Assigned ID#
<b>Contracted Broker:</b>	EBCA	54-2015926	98D
<b>Sub-Agent/Sub-Agency:</b>	Thomas Musembi		
<b>Writing Agent:</b>			

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**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.)	Medical Center or PCP Name (Include PCP ID #)
Spouse						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Partner						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F			Name PCP ID #

**4. OTHER INSURANCE INFORMATION**

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

- |  |            |           |
|--|------------|-----------|
|  | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|
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 BlueChoice 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): \_\_\_\_\_

**5. 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.

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

**SECTION 5A — 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:**

- |  |            |           |
|--|------------|-----------|
|  | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|
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 .....

## 5. HEALTH EVALUATION (Continued)

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 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, infertility, 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, infertility .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Sexually transmitted diseases .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Anemia, blood disorders .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. 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 1-18? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. 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 5B — If you have checked "YES" to any part of SECTION 5A, 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 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

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

## 5. HEALTH EVALUATION (Continued)

**SECTION 5C — If any person included in this application is presently using medication or prescription drugs, please provide the following information.**

Name of Family Member	Illness or Condition	Medication	Date of Last Treatment	Operation (Yes or No)	Attending Physician Name and Address

## 6. 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 CareFirst BlueChoice, Inc. (CareFirst BlueChoice).

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

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 BlueChoice 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 BlueChoice 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 BlueChoice.

By signing this Application, I hereby authorize CareFirst BlueChoice to disseminate and share non-health questionnaire information contained on this Application with the Health Savings Account (HSA) preferred bank(s) affiliated with CareFirst BlueChoice. 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 HSA bank. The authorization shall continue until my enrollment with CareFirst BlueChoice terminates or at any time that I provide a written instruction to CareFirst BlueChoice revoking this authorization or if this authorization terminates by operation of law.

**If you do not want information on this Application shared with the HSA 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 BlueChoice due to medical underwriting may not submit a subsequent Application for enrollment within ninety (90) days of the denial.

**6. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully (continued)**

**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 BlueChoice 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: \_\_\_\_\_

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

Signature of Applicant 1:\* X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Applicant 2: X \_\_\_\_\_ Date: \_\_\_\_\_

\* 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: \_\_\_\_\_