Individual Select Preferred Dental Application

Virginia

CareFirst BlueCross BlueShield

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

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print all information.
2. Sign and return this application, with exact payment amount, in the postage-paid return envelope or, to **P.O. Box 79810 Baltimore MD 21298-8159**

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If payment amount is incorrect, the application will be returned.***

For Faster Processing Please Make Check Payable to: **THE DENTAL NETWORK, INC.** and mail to:

THE DENTAL NETWORK
P. O. BOX 79810
Baltimore MD 21279-0810

Questions! Call Tom @ tel: (888)490-8782
or email: insurance@rxmom.com

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

Residence Address: Number and Street, Apt. #	City and State	Zip Code (9-digit, if known)

Date of Birth / /	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Payment Option ☐ Annual ☐ Semi-annual

Home Phone ( )	Work/Cell 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)

A "Child" means your eligible child up to age 26. Eligibility requirements are defined in your contract.

An "Adult" means the Spouse or Domestic Partner of the Subscriber who satisfies the eligibility requirements defined in your contract.

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
Spouse						☐M ☐F
Domestic Partner						☐M ☐F
Dependent 1						☐M ☐F
Dependent 2						☐M ☐F
Dependent 3						☐M ☐F

4. 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.
- 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.
- Premium payment options are available on an annual and a semi-annual basis. Those members who elect the semi-annual payment option will be subject to an additional five dollar ($5) surcharge per payment, which equals to ten dollars ($10) annually.
- 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.
- 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 toll-free at (888) 833-8464 before signing this application.

WARNING: 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.

The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Signature of Applicant: X _____ Date: _____

Signature of Dependent: X _____ Date: _____

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 Signature: X _____ Date: _____

Signature of Agent: X _____ Date _____

Please make checks payable to:

CAREFIRST BLUECROSS BLUESHIELD
and mail to:
Dental Processing Center
P.O. Box 79810
Baltimore, MD 21298-8159

AGENTS MUST COMPLETE THIS SECTION

Agency Name

RxMom.com Insurance Service Agent Thomas Musembi AGENT #20200

Agency Address: Number and Street, Apt.#	City and State	Zip Code (9-digit, if known)
4800 Hampden Ln Suite 200	Bethesda Maryland	20814

Telephone Number	Fax Number	E-mail Address
(888) 490-8782	(866) 204-8857	insurance@rxmom.com

Annual or Semi-annual Premium

CareFirst BlueCross BlueShield

Individual Dental Rates
District of Columbia and Virginia

Individual Select Preferred Dental

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application
Individual	$151.44
Individual & Child(ren)	$280.20
Individual & Adult	$302.88
Family	$424.08

Coverage Type	Semi-Annual Rate Second Payment Due by the 1st of the Seventh Month from the Effective Date of Coverage	
	1ST PAYMENT	2ND PAYMENT
Individual	$80.72	$80.72
Individual & Child(ren)	$145.10	$145.10
Individual & Adult	$156.44	$156.44
Family	$217.04	$217.04

Please note that when selecting the semi-annual payment, a $5.00 administration fee is already included into each payment. You pay an additional $10/year when you select the semi-annual payment option. The first payment (of the semi-annual rate) is due with the enrollment application.

The second payment is due by the 1st of the seventh month from the effective date of coverage. For example, if coverage is effective January 1, the second payment is due July 1.

CUT9296-9N (4/11)