Individual Select Preferred Dental Application

District of Columbia

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, in the postage-paid return envelope if provided, or mail to:
   Mailroom Administrator
   P.O. Box 14651, Lexington, KY 40512

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed.

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

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

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

Date of Birth / /	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Domestic Partnership/Other
Home Phone ( )	Work/Cell Phone ( )	Payment Option ☐ Annually ☐ Quarterly

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, Domestic or Civil Union 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	Sex
Spouse							☐ M ☐ F
Domestic Partner; Legal Partner; or Civil Union Partner							☐ M ☐ F
Dependent 1							☐ M ☐ F
Dependent 2							☐ M ☐ F
Dependent 3							☐ M ☐ F
Dependent 4							☐ M ☐ F
Dependent 5							☐ M ☐ F

4. PLAN SELECTION — Check one

☐ **Individual Select Preferred Dental** is a **Preferred Provider Organization (PPO)** plan underwritten by Group Hospitalization and Medical Services, Inc. *This is a preventive services plan.*

☐ **Individual Select Preferred Dental Plus** is a **Preferred Provider Organization (PPO)** underwritten by Group Hospitalization and Medical Services, Inc.

All individuals listed on this application will be enrolled in the plan selected. Any individual who wants to enroll in a different plan must fill out a separate application.

5. ELECTRONIC COMMUNICATION CONSENT

CareFirst BlueCross BlueShield (CareFirst) 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 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 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: This consent for electronic communications applies to the Primary Applicant only. Spouse, Domestic or Civil Union Partners and dependents 18 years of age and older can consent to electronic communications through **www.carefirst.com/myaccount**. Members can also change email 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.

Primary Applicant Name	Email Address	Cell Phone Number
	Alternate Email Address	Alternate Cell Phone Number

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

Signature: X

CareFirst will not sell your email or phone number to any third party and we do not share it with third parties except for CareFirst business associates that perform functions on our behalf or to comply with the law.

6. CONDITIONS OF ENROLLMENT — Please read this section carefully

IT IS UNDERSTOOD AND AGREED THAT:

- A copy of this application will be provided to the Subscriber (or to a person authorized to act on his/her behalf).
- 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 quarterly basis.
- 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 866-891-2802 before signing this application.

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: 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: _____

FOR OFFICE USE ONLY:

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

Signature of Primary Applicant: X	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN #	Tax ID #	CareFirst-Assigned ID #
Contracted Broker:		[redacted]		
Sub-Agent/Sub-Agency:				[redacted]
Writing Agent:				