

Instructions for a Student Health Plan

Qualifying Life Event Coverage

Follow the steps below to add coverage for yourself OUTSIDE the Open Enrollment period. NOTE: You must be eligible for a qualifying life event.

1. Print out and complete the Qualifying Life Event Form for Students.
2. Gather the required qualifying life event supporting documentation.
3. NOTE: A list of eligible events and required documentation is below. You must send the appropriate supporting documentation and apply within the eligibility period to qualify for coverage. For a full list of qualifying life events and required documentation, please contact your university's insurance administrator.
4. Send the Qualifying Life Event Form for Students and proof of your qualifying life event to your university's insurance administrator.
5. No payment is required at this time. You will be billed at a later date through your university tuition.
6. Confirm that your coverage has been processed by calling your university's insurance administrator.

QUALIFYING LIFE EVENT	REQUIRED DOCUMENTATION	TIMELINE
You got married	Send a copy of the marriage certificate	60 days from the marriage
You had a baby	Send a copy of the birth certificate OR vital statistic submission letter on hospital letterhead	60 days from the birth
You or your family have been covered under a non-calendar year group health plan or individual health insurance policy	Send the renewal notice or other statement from applicable insurance carrier on company letterhead	60 days prior to renewal date and 60 days post renewal date
You completed full term COBRA coverage or refused COBRA coverage after a recent employment termination	Send official termination notice from applicable insurance program or employer on letterhead, including reason for termination	60 days prior to coverage termination and 60 days post coverage termination
You will lose or have lost minimum essential coverage not including failure to pay premiums or rescissions	Official termination notice from applicable insurance program or employer on letterhead, including reason for loss of coverage	60 days prior to coverage termination and 60 days post coverage termination
You got divorced	Send a copy of the divorce decree	60 days from the divorce

For a full list of qualifying life events and documentation, please contact your university insurance administrator.

4. ELECTRONIC COMMUNICATION CONSENT *(to be completed by student only)*

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 Student Applicant only. Members can also change email and consent information anytime by logging into **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.

Student 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		

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.

5. CONDITIONS OF COVERAGE

I understand this form to add coverage is subject to the approval of CareFirst and _____
(Name of School)
and subject to the payment of any applicable premium. Once this form has been approved, coverage cannot be canceled, except for eligibility reasons.

MARYLAND WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DISTRICT OF COLUMBIA 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, an insurer may deny insurance benefits if false information, materially related to a claim, was provided by the subscriber.

VIRGINIA 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.

6. REQUIRED SIGNATURE(S) AND DATE	
Student Signature	Date / /
Parent or Legal Guardian's Signature	Date / /
Name of Individual Completing Form (if other than student)	Relationship to Student

Complete this form and return it with the correct supporting documentation to your university's insurance administrator.

7. RACE, ETHNICITY, LANGUAGE <i>(this information is voluntary)</i>					
<p>CareFirst is asking its members to voluntarily provide their race, ethnicity and language attributes. The information provided, while voluntary, will assist us to improve the quality of care and access to care thereby reducing health care disparities and promote better health outcomes. The information you provide will not have a negative impact on any services we provide you. The information is kept strictly confidential and will not be shared unless required by law to disclose it.</p>					
Race		Ethnicity		Preferred Spoken Language*	
White/Caucasian		Hispanic/Latino/		01 English	10 French (European)
Black or African American		Spanish origin		02 Albanian	11 Greek
American Indian or Alaska Native				03 Amharic	12 Gujarati
Asian				04 Arabic	13 Hindi
Native hawaiian or other pacific islander				05 Burmese	14 Italian
Other – (To include Multi-Racial)				06 Cantonese	15 Korean
Decline to answer				07 Chinese (simplified & traditional)	16 Mandarin
Unknown – Could not be determined				08 Creole (Haitian)	17 Portuguese (Brazilian)
				09 Farsi	18 Russian
					19 Serbian
					20 Somali
					21 Spanish (Latin America)
					22 Tagalog (Filipino)
					23 Urdu
					24 Vietnamese
					98 Other and unspecified languages
					99 Unknown
Student Applicant Last Name	First Name	Race	Ethnicity	Country of Origin	Preferred Spoken Language (specify number from above*)

Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address P.O. Box 8894
 Baltimore, Maryland 21224

Email Address civilrightscoordinator@carefirst.com

Telephone Number 410-528-7820

Fax Number 410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

አማርኛ (Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መደን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላሉ። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ̀tílẹ̀kọ: Àkíyèsí yìí ní iwífún nípa isẹ̀ adójú tòfò rẹ̀. Ó le ní àwọn déèti pátó o sì le ní láti gbé igbésẹ̀ ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yí àti irànlówó ní èdè rẹ̀ lófèfè. Àwọn omo-egbé gbòdò pe nòmbà fòdùn tò wà léyìn kààdi idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijiròrò tí tí a ó fí sọ fún ọ̀ láti tẹ̀ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ̀ a ó sì sọ ọ̀ pò mò ògbufò kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.



हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsɔ̀-wùdù (Bassa) Tò Òùù Cáo! Bǎ̀ nǎ̀ ke bá nyɔ̀ bɛ̀ ké m̀ gbo kpá bó nì fùà-fùá-tìŋ nyɛɛ jè dyí. Bǎ̀ nǎ̀ ke bédé wé jéé bɛ̀ bɛ̀ m̀ ké dɛ̀ wa m̀ m̀ ké nyuɛɛ nyu hwɛ̀ bɛ̀ wé bɛ̀a ké zi. ɔ̀ m̀ nì kpé bɛ̀ m̀ ké bǎ̀ nǎ̀ ke kè gbo-kpá-kpá m̀ m̀wɛɛ dyé dɛ̀ nì bídí-wùdù mú bɛ̀ m̀ ké se wídí d̀ pɛ̀dɛ̀. Kpooò nyɔ̀ bɛ̀ mɛ̀ d́ fúùn-nòbà nǎ̀ dɛ̀ waà I.D. káàò dɛ̀ín nyɛ̀. Nyɔ̀ t̀òò séín mɛ̀ d́ nòbà nǎ̀ ke: 855-258-6518, ké m̀ mɛ̀ fò tee bɛ̀ wa kée m̀ gbo cɛ̀ bɛ̀ m̀ ké nòbà m̀òà 0 kɛɛ dyi pàdà̀n hwɛ̀. ɔ̀ jù ké nyɔ̀ d̀ò dyi m̀ gǎ̀ jùŋn, po wuɔ̀ m̀ m̀ pɔe dyiɛ̀, ké nyɔ̀ d̀ò mu bó nìin bɛ̀ ɔ̀ ké nì wuɔ̀d̀ò mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للأخريين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。



Igbo (Igbo) Nruḅama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughị ugwo o bula. Ndi otu kwesiri ikpo akara ekwentị di n'azu nke kaadi njirimara ha. Ndi ozọ niile nwere ike ikpo 855-258-6518 wee chere ububo ahụ ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejikọ gi na onye okowa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아닌 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad (Navajo) Ge': Díí bee íł hane'ígíí bii' dahólq bee éédahózin béeso ách'ááh naanil ník'ist'i'ígíí bá. Bii' dahólq doo íiyisí yoolkáálgíí dóó t'áadoo le'é ádadoolyíllígíí da yókeedgo t'áa doo bee e'e'aahí ájiil'íh. Bee ná ahót'i' díí bee íł hane' dóó níká'ádoowoł t'áa nínizaad bee t'áa jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nitł'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náánáta' éi koji' dahódoonih 855-258-6518 dóó yii diilts'íł yatl'ígíí t'áa níléijí áádóo éi bikéé'dóo naasbaas bił adidiilchił. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yánilt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoowoł.

