Virginia Medical Plans

Application Instructions for CareFirst

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter and application and fax or mail to Virginia Medical Plans for signature. If you do not have access to a fax machine, send the completed application to Virginia Medical Plans along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Select your preferred billing method.
- Sign and date the application.
- Estimated first month's premium must accompany the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to CareFirst** if you are not paying by credit card for the first month.

Mail completed applications and check to:

Virginia Medical Plans
Attn: New Enrollment
1404 Northpoint Glen Ct.
Herndon, VA 20170

Virginia Medical Plans will review your application for completeness and accuracy before submiting it to CareFirst for processing. This may reduce the underwritting time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 800-867-0800 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

Virginia Medical Plans

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Virginia Medical Plans
FAX# 888-514-4258

Dear Virginia Medical Plans,
Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact Virginia Medical Plans at 800-867-0800 to verify receipt of my application.

I will send the original application as soon as I have been contacted by Virginia Medical Plans with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

Individual Application
Virginia Residents

CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Group Hospitalization and Medical Services, Inc.
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. 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. ***If incomplete, the application will be returned and your coverage will be delayed.***

Are you applying for new coverage or are you making changes to a current policy? Check one box.
☐ New coverage ☐ Making changes

1. PRIMARY APPLICANT INFORMATION (The primary applicant will be the Head of Household)

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

Date of Birth	Sex	Marital Status
/ /	☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner
Home Phone	**Work/Cell Phone**	**Tobacco Usage***
( )	( )	☐ Yes ☐ No

*Tobacco usage means any use of tobacco, including but not limited to cigarettes, for other than religious or ceremonial use, on average four or more times per week within the past 6 months.

2. ENROLLING FAMILY MEMBER(S) (Complete only if you are enrolling a Spouse, Partner or Dependent(s) to your plan)

	Last Name	First Name	M.I.	Relationship	Social Security #	Date of Birth	Sex	Tobacco Usage
Spouse							☐ M ☐ F	☐ Yes ☐ No
Domestic Partner							☐ M ☐ F	☐ Yes ☐ No
Dependent 1							☐ M ☐ F	☐ Yes ☐ No
Dependent 2							☐ M ☐ F	☐ Yes ☐ No
Dependent 3							☐ M ☐ F	☐ Yes ☐ No
Dependent 4							☐ M ☐ F	☐ Yes ☐ No
Dependent 5							☐ M ☐ F	☐ Yes ☐ No
Dependent 6							☐ M ☐ F	☐ Yes ☐ No
Dependent 7							☐ M ☐ F	☐ Yes ☐ No
Dependent 8							☐ M ☐ F	☐ Yes ☐ No

3. PLAN SELECTION (Check one)			
Plan Name		**Deductible**	
Health Maintenance Organization (HMO) Plans Underwritten by CareFirst BlueChoice, Inc.		**In-Network**	**Out-of-Network**
☐	BlueChoice Young Adult $6,350*	Individual: $6,350 Family: $12,700	N/A
BlueChoice Young Adult is only available for individuals under age 30. Some exceptions may apply.			
☐	BlueChoice HSA Bronze $6,000*	Individual: $6,000 Family: $12,000	N/A
☐	BlueChoice HSA Bronze $4,000*	Individual: $4,000 Family: $8,000	N/A
☐	BlueChoice Silver $2,000*	Individual: $2,000 Family: $4,000	N/A
☐	BlueChoice HSA Silver $1,300*	Individual: $1,300 Family: $2,600	N/A
☐	BlueChoice Gold $1,000*	Individual: $1,000 Family: $2,000	N/A
☐	BlueChoice Gold $0*	Individual: $0 Family: $0	N/A
Point of Service (POS) Plans Underwritten by CareFirst BlueChoice, Inc. for in-network benefits and by Group Hospitalization and Medical Services Inc. for out-of-network benefits.			
☐	BlueChoice Plus Bronze $5,500*	Individual: $5,500 Family: $11,000	Individual: $6,350 Family: $12,700
☐	BlueChoice Plus Silver $2,500*	Individual: $2,500 Family: $5,000	Individual: $5,000 Family: $10,000
☐	HealthyBlue Gold $1,500*	Individual: $1,500 Family: $3,000	Individual: $2,500 Family: $5,000
☐	HealthyBlue Platinum $0*	Individual: $0 Family: $0	Individual: $1,000 Family: $2,000
Preferred Provider Organization (PPO) Plans Underwritten by Group Hospitalization and Medical Services, Inc.			
☐	BluePreferred HSA Bronze $3,500	Individual: $3,500 Family: $7,000	Individual: $7,000 Family: $14,000
☐	BluePreferred HSA Silver $1,500	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000
☐	BluePreferred Gold $500	Individual: $500 Family: $1,000	Individual: $1,000 Family: $2,000
☐	BluePreferred Platinum $0	Individual: $0 Family: $0	Individual: $1,000 Family: $2,000

Important Deductible Information:

For HSA Plans (HSA listed in plan name): Single party applications: the Individual Deductible must be met before full benefits will begin. Multi-party applications: the Family Deductible must be met before full benefits will be available to any member on the policy. Once the Family deductible has been met, full benefits will become available to everyone covered.

For non-HSA Plans (HSA is not listed in plan name): Single party applications: the Individual Deductible must be met before full benefits will begin. Multi-party applications: if one member on the policy meets the Individual Deductible, full benefits will begin for that member. That member will not be able to contribute more than the Individual Deductible amount towards the Family Deductible. Once the Family Deductible has been met, full benefits will be available to all members on the policy.

Please Note: Coverage will begin immediately for preventive benefits as they are not subject to a deductible. Other benefits, as specified in the member contract, also may be covered without having to meet a deductible first. In-network and out-of-network (if applicable) deductible expenses will not be applied to each other.

4. PRIMARY CARE PHYSICIAN INFORMATION

*If you selected a BlueChoice or HealthyBlue plan in Section 3, please select a Primary Care Physician from the CareFirst BlueChoice Directory available at www.carefirst.com/doctor. Indicate the PCP ID number for all enrolling applicants below:

Applicant Name	PCP ID
Spouse/Domestic Partner	**PCP ID**
Eligible Dependent Name(s)	**PCP ID**

5. OTHER INSURANCE INFORMATION

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

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 and 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 coverage replace your existing policy? ☐ Yes ☐ No

3. Has anyone listed on this application been without health insurance for the past 12-months or longer? ☐ Yes ☐ No

   If yes, please list name(s):

6. NON-OPEN ENROLLMENT APPLICATION ELIGIBILITY

Do you qualify for a Limited Open Enrollment period based on one of the five triggering events listed below? If YES, please select the triggering event to determine your eligibility. You will be required to provide documentation as proof of your triggering event. If NO, please skip to Section 7.	☐ Yes ☐ No
1. Are you adding a qualified dependent, recognized through marriage, birth, adoption or court-appointed within the last 60 days, to your plan?	☐ Yes ☐ No
2. Within the last 60 days, were you enrolled in a qualified health plan in which:	
You lost minimum essential coverage (not including failure to pay premiums or rescissions)?	☐ Yes ☐ No
You experienced an error in enrollment by the Health Insurance Marketplace in Virginia or by the Department of Health and Human Services?	☐ Yes ☐ No
The plan substantially violated a material provision of its contract?	☐ Yes ☐ No
3. Within the last 60 days, have you or your dependents become newly ineligible for subsidies?	☐ Yes ☐ No
4. Within the last 60 days, have you gained access to new Qualified Health Plans as a result of a permanent move?	☐ Yes ☐ No
5. Within the last 30 days, were you terminated from a non-calendar year individual health insurance policy?	☐ Yes ☐ No

7. RECURRING AUTOMATED PREMIUM PAYMENT

CareFirst wants to help you save time! Our standard method of payment for members is recurring automated payment by bank withdrawal. To take advantage of this time-saving payment option, please fill out the information below.

If you do not wish to set up an automated payment account and intend to pay by submitting paper checks or by credit card then please check this box. ☐

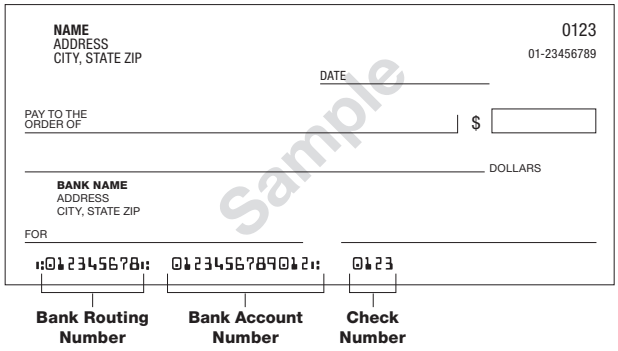
Information Required for Recurring Automated Payment:

☐ **Checking Account** ☐ **Savings Account**

Bank Name:

Routing Number:	Account Number:

Name that appears on the Account:



I hereby authorize CareFirst to charge my account for the payment of premiums due for an unpaid invoice. If any check draft is dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, CareFirst agrees that the financial institution will not be held liable. I understand that non-payment of premiums due to dishonored auto-draft payment attempts may result in termination of coverage. I also understand that if the Primary Applicant elects to pay premium through an electronic payment, CareFirst may not debit or charge the amount of the premium due prior to the premium due date, except as authorized by the Primary Applicant. My recurring payments will be processed on the 6th of each month (including holidays). Members registered for recurring automated premium payment will not receive a paper bill in the mail. However, you may view and print your invoice during the recurring automated payment period from the invoice history online at **www.carefirst.com/myaccount.**

Signature of Account Holder X	Date:

8. ELECTRONIC COMMUNICATION CONSENT

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, you may change your 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.

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

Primary Applicant Name	Email Address	Cell Phone Number
	Alternate Email Address	Alternate Cell Phone Number
Spouse / Domestic Partner Name	Email Address	Cell Phone Number
Eligible Dependent Name(s)	Email Address	Cell Phone Number

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.

9. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Primary Applicant (or to a person authorized to act on his/her behalf) upon request, from CareFirst.

I understand that I have the right to cancel this authorization at any time, in writing, except to the extent that CareFirst has already taken action in reliance on this authorization. I also understand that CareFirst Notice of Privacy Practices includes information pertaining to authorizations and to requirements of revocation. A copy of the Notice may be obtained by contacting the CareFirst Privacy Office. CareFirst is required to tell you by law that information disclosed pursuant to this authorization may be subject to re-disclosure and that under some limited circumstances will no longer be protected by federal privacy regulations.

If CareFirst determines that additional information is needed, I will receive an authorization to release that information. Failure to execute an authorization may result in the denial of my application for coverage. Additionally I understand that failure to complete any section of this application, including signing below, may delay the processing of my application.

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. CareFirst will provide 30-days advance written notice of any rescission of coverage and refund any premiums to the Primary Applicant. The Member is responsible for repayment of any claim payment made by CareFirst on the Member's behalf.

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.

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/her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

Signature of Primary Applicant: X	Date
Signature of Applicant 2: X (Spouse or Domestic Partner)	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's Signature: X	Date
Signature of Agent: X	Date

FOR OFFICE USE ONLY:

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

Signature of Primary Applicant: X	Date
Signature of Applicant 2: X (Spouse or Domestic Partner)	Date
Parent or Legal Guardian's Signature: X	Date

FOR BROKER USE ONLY:	Name:	NPN#	SSN/Tax ID #	CareFirst-Assigned ID #
Contracted Broker:	EBCA		54-2015926	98D
Sub-Agent/Sub-Agency:				[redacted]
Writing Agent:	Jonathan Katz	1585616	228210944	