# Apply Today

# Apply Today for Individual Select Preferred

## Three steps to apply!

1) Fill out and sign the application that matches where you live – Maryland, the District of Columbia or Northern Virginia.

   Choose the annual or semi-annual payment option.

2) When you're ready to review a listing of providers, please visit **www.carefirst.com/findadoc**. Click on Dental, and select *Individual Select PPO*. Or, if you'd like to request a printed directory, please call a Product Consultant at (410) 356-8000 or toll-free at (800) 544-8703, Monday–Friday, 8 a.m.–8 p.m.

3) Send in your application, with your payment, in the enclosed, postage-paid envelope or mail to:

   CareFirst BlueCross BlueShield
   P.O. Box 79810
   Baltimore, MD 21279-0810

Payments must be deposited on or before the last business day of each month to ensure coverage will be effective on the first of the next month.

CareFirst will mail your membership cards and certificate of coverage to you. Then you can start enjoying all the benefits of good dental care.

**Please note:** you must live in Maryland, the District of Columbia or one of the following areas of Northern Virginia: City of Alexandria and Fairfax, the town of Vienna, Arlington county and the areas of Fairfax and Prince William counties in Virginia lying east of Route 123.

It takes just three simple steps to start enjoying the benefits of Individual Select Preferred Dental.

# Application for Maryland Residents

Please fill out the Maryland Individual Select Preferred Dental application on the following pages, if you live in the state of Maryland.

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Remember to send in your application, with your payment, so you can start enjoying all the benefits of good dental care!

| Coverage Type | Annual Rate<br>Full Annual Payment Due with Enrollment Application | Semi-Annual Rate<br>Second Payment Due by the 1st of the seventh month from the effective date of coverage | |
|---|---|---|---|
| | | 1st Payment | 2nd Payment |
| Individual | $151.80 | $80.90 | $80.90 |
| Individual & Child(ren) | $280.80 | $145.40 | $145.40 |
| Individual & Adult | $349.20 | $179.60 | $179.60 |
| Family | $425.04 | $217.52 | $217.52 |

# Individual Select Preferred Dental Application

Maryland

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 21279-0810**

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.***

## 1. APPLICANT INFORMATION

| Last Name | First Name | Middle 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 ☐ 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)

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

"Adult" means the Spouse or Partner 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/Partner | | | | | | | ☐M ☐F |
| Dependent 1 | | | | | | | ☐M ☐F |
| Dependent 2 | | | | | | | ☐M ☐F |
| Dependent 3 | | | | | | | ☐M ☐F |
| Dependent 4 | | | | | | | ☐M ☐F |
| Dependent 5 | | | | | | | ☐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) fee per payment, which equals 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 BlueCross BlueShield 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 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.**

**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: _____

## Please make checks payable to:

**CAREFIRST BLUECROSS BLUESHIELD**
**and mail to:**

**Dental Processing Center**
P.O. Box 79810
Baltimore, MD 21279-0810

**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 200 Bethesda MD 20814 | | |
| Telephone Number<br>( 888 ) 490-8782 | Fax Number<br>( ) | E-mail Address<br>insurance@rxmom.com |
| Annual or Semi-annual Premium | | |