

**MEMBERSHIP APPLICATION**

**DENTAL ONLY**



PLEASE PRINT – PRESS FIRMLY

10455 Mill Run Circle, Owings Mills, MD 21117

**ADDRESS CHANGE**

<b>1. TYPE OF REQUEST</b> <input type="checkbox"/> NEW MEMBER <input type="checkbox"/> CHANGE OF COVERAGE <input type="checkbox"/> CHANGE OF SUBSCRIBER OR DEPENDENT INFORMATION <input type="checkbox"/> RE-ENROLLMENT <input type="checkbox"/> TERMINATION OF DEPENDENT														
<b>2. SUBSCRIBER INFORMATION (YOUR EMPLOYER WILL COMPLETE THE 4 SHADED BOXES IN THIS SECTION.)</b>														
Last Name			First Name		MI		Social Security/Membership No.			Group Number				
Street Address				Apt. No.		Employment Date			Department Number					
City			State		Zip		Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired			Effective Date				
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth		Home Phone Number			Business Phone Number		Ext.		Employee/Payroll Number				
Subscriber's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Date of Marriage		Name of Employer										
<b>3. MEDICARE AND TERFA INFORMATION</b>														
If Eligible for Medicare:			Claim No.			Hospital Insurance Effective Date			Hospital Insurance Effective Date			Medical Insurance Effective Date		
If actively employed and TEFRA applicable, complete primary carrier selection. Subscriber: Blue Cross <input type="checkbox"/> or Medicare <input type="checkbox"/> Spouse: Blue Cross <input type="checkbox"/> or Medicare <input type="checkbox"/>														
<b>4. OTHER HEALTH INSURANCE INFORMATION – (WE REQUIRE THE INFORMATION REQUESTED IN THIS SECTION.)</b>														
Do you or your dependents have any other health insurance policy or Blue Cross/Blue Shield other than through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No						Name of Spouse's Employer:								
If yes, Name of Person Covered						Name of Insurance Company:								
Date of Birth:						City:			State:					
Name of Employer:						Policy or Certificate No.:								
If covered by Maryland or other Blue Cross/Blue Shield Plan:						Membership No.:								
						City:			State:					
<b>5. COVERAGE LEVEL SELECTION</b>														
Check coverage level desired <input type="checkbox"/> Individual <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Parent & Child <input type="checkbox"/> Family														
<b>6. GENERAL DEPENDENT INFORMATION</b>														
Add or Change A or C	If the LAST NAME of a child is DIFFERENT, check the "Sole Support" column to indicate that you provide the sole support for the minor dependent.					Sole Support	S	E	R	E	Date of Birth	Social Security Number		
	Spouse	Last Name	First	M.I.		<input type="checkbox"/>			SP					
	Child					<input type="checkbox"/>			CH					
	Child					<input type="checkbox"/>			CH					
	Child					<input type="checkbox"/>			CH					
	Child					<input type="checkbox"/>			CH					
	Child					<input type="checkbox"/>			CH					
	Child					<input type="checkbox"/>			CH					
<b>7. DETAILED DEPENDENT INFORMATION – ARE ANY OF YOUR DEPENDENTS:</b>														
Covered by Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes						Name:			Medicare No.:					
Handicapped? No <input type="checkbox"/> Yes <input type="checkbox"/>						Effective Date			Effective Date					
Full time college student? No <input type="checkbox"/> Yes <input type="checkbox"/>						Name:			Name:					
						School Name:			School Name:					
<b>8. TERMINATION OF DEPENDENTS</b>														
Do NOT use this section to change coverage level. See Instructions: Dependent Termination Only.						Write Correct Reason Code			Reason Codes					
Name						Date of Reason			Reason					
Name						Date of Reason			Reason					
									1. Divorce    2. Death    3. Entered Military					
									4. Child reached eligibility age limit    5. Other					

**READ CAREFULLY. THIS APPLICATION, WHEN ACCEPTED, IS PART OF THE CONTRACT.**

I hereby apply, on behalf of myself and each dependent listed above, for the health coverage indicated. If this application is accepted, coverage will be provided according to the terms and conditions of the health care contract between CareFirst BlueCross BlueShield and my employer. I agree to be bound by that health care contract and to pay current and future charges for the health coverage provided. My employer is authorized to deduct the appropriate amount for such charges from my pay for that purpose.

I hereby authorize any physician, hospital, or other provider of service to furnish any information, reports, records, or copies of records, relating to care or services rendered to me or any of the dependents listed above to, CareFirst BlueCross BlueShield. Such information is to be held confidential.

I have carefully read this application and agree to its terms. The information provided is true and complete and is submitted in order to cause the issuance of the health coverage selected.

**THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE ANY SECTION MAY DELAY CLAIMS PAYMENT.**

EMPLOYEE'S SIGNATURE (Subscriber) \_\_\_\_\_ DATE \_\_\_\_\_

SPOUSE'S SIGNATURE (Required for TEFRA) \_\_\_\_\_ DATE \_\_\_\_\_

**REMOVE PAGE 1 & 2, ATTACH TO A TRANSMITTAL (UNT0003-1S OR UNT0005-1S), THEN FORWARDED ALL TO CAREFIRST BLUECROSS BLUESHIELD OR YOUR ADMINISTRATOR.**

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