Apply Today for Individual Select Dental HMO

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 Dental HMO*. Or, if you'd like to request a printed directory, please call our Product Consultants 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 premium payment**, in the enclosed, postage-paid envelope or mail to:

   The Dental Network and CareFirst BlueChoice, Inc.
   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.

We 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 Dental HMO.

Individual Select Dental HMO Application

District of Columbia

CareFirst BlueChoice, 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 21298-8159**

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.***

For Faster Processing Please Make Check Payable to: THE DENTAL NETWORK, INC and Mail to:

THE DENTAL NETWORK
P O BOX 79810
Baltimore MD 21279-0810

Questions ! Please call Tom at (888)490-8782 or email : insurance@rxmom.com

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 ☐ Domestic Partnership	Dental Office Code
Home Phone ( )	**Work/Cell Phone** ( )	**E-mail Address**	**Payment Option** ☐ Annual ☐ Semi-annual

2. COVERAGE SELECTION: (Check one)

☐ **Individual** - Provides coverage for one person
☐ **Individual & Child** - Provides coverage for an individual and eligible dependent (if you have more than one child, you must select Family coverage)
☐ **Individual & Adult** - Provides coverage for two eligible adults
☐ **Family** - Provides coverage for up to 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 or Domestic 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, Individual & Adult or Family Coverage**

(You must have a dental code. Each person may select their own dentist.)

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	Dental Office Code
Spouse/Domestic Partner						☐M ☐F	
Dependent 1						☐M ☐F	
Dependent 2						☐M ☐F	
Dependent 3						☐M ☐F	
Dependent 4						☐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) surcharge 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 BlueChoice 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: 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 BLUECHOICE, INC. MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature of Applicant: X _____ Date:_____

Signature of Dependent: 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.

Signature of Legal Guardian: X _____ Date:_____

Please make checks payable to:

CAREFIRST BLUECHOICE, INC.
and mail to:

Dental Processing Center
P.O. Box 79810
Baltimore, MD 21298-8159

AGENTS MUST COMPLETE THIS SECTION

Agency Name		
RXMOM INSURANCE AGENT: THOMAS MUSEMBI AGENT #20200		
Agency Address: Number and Street, Apt.#	City and State	Zip Code (9-digit, if known)
4800 HAMPDEN LN SUITE 200 BETHESDA MD 20814		
Telephone Number	Fax Number	E-mail Address
(888)490-8782	(866) 204-8857	INSURANCE@RXMOM.COM
Annual or Semi-annual Premium		

Rates

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application	Semi-Annual Rate Second Payment Due by the 1st of the seventh month from the effective date of coverage	
		1st Payment	**2nd Payment**
Individual	$120	$65	$65
Individual & Child	$204	$107	$107
Individual & Adult	$240	$125	$125
Family	$360	$185	$185

Please note that when selecting the semi-annual payment, a $5 administration fee is already included into each payment. You pay an additional $10/year when you select the semi-annual payment option. The first payment (of the semi-annual rate) is due with the enrollment application.

The second payment is due by the 1st of the seventh month from the effective date of coverage. For example, if coverage is effective January 1, the second payment is due July 1.