CareFirst BlueCross BlueShield

CareFirst BlueChoice

Primary Caretaker Certification

ID Number: _____ Group Number: _____
Dependent Name: _____ Date Of Birth: _____
Relationship To Subscriber: _____

Please review each statement thoroughly. In the space provided, please initial to confirm your understanding.

_____ The dependent whose name appears above is my: grandchild, niece, nephew (**Circle correct relationship**).

_____ The legal guardian of the dependent whose name appears above is not covered by an accident or sickness policy (health insurance).

_____ The dependent whose name appears above is in the primary care of the subscriber. Primary care means the subscriber provides food, clothing and shelter on a regular and continuous basis.

_____ The dependent whose name appears above is no longer in the primary care of the subscriber effective _____.

_____ The legal guardian of the dependent whose name appears above is covered by an accident or sickness policy (health insurance) effective _____.

In the space provided below please write the name and address of the parent's or legal guardian's employer. **We reserve the right to contact the employer listed to confirm that the parent or legal guardian does not have health insurance**.

_____
_____
_____
_____

Please sign this form in the space below. By signing this form the subscriber and parent or legal guardian of the dependent named above certify that the above facts are true. Coverage for the dependent will be terminated if it is determined that the above information is incorrect or if the dependent loses eligibility.

_____ _____
Signature of Subscriber & Date Signature of Parent or Legal Guardian & Date

Please return this form to:

CareFirst BlueCross BlueShield/CareFirst BlueChoice, Inc.
550 12th Street, SW
Washington, DC 20065
Attention: Account Implementation Department

CUT5858-1S (3/02)