

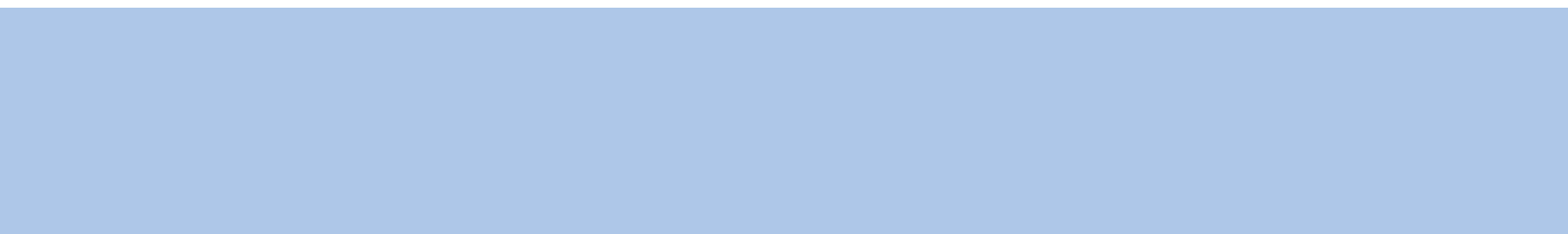
Rates

| Coverage Type | Annual Rate Full Annual Payment Due with Enrollment Application | Semi-Annual Rate Second Payment Due by the 1 st 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.

Apply Today



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.

Application for Northern Virginia Residents

Please fill out the Virginia Individual Select Dental HMO application on the following pages, if you live in the cities 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.

Individual Select Dental HMO Application

Virginia



CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

| INSTRUCTIONS |
|---|
| <p>1. Please fill out all applicable spaces on this application. Print all information.</p> <p>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</p> <p>Give careful attention to all questions in this application. <u>Accurate, complete</u> information is necessary before your application can be processed. <i>If payment amount is incorrect, the application will be returned.</i></p> |

**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 <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner | Dental Office Code |
| Home Phone () | Work/Cell Phone () | E-mail Address | Payment Option <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual |

| 2. COVERAGE SELECTION: (Check one) |
|--|
| <p><input type="checkbox"/> Individual - Provides coverage for one person</p> <p><input type="checkbox"/> Individual & Child - Provides coverage for an individual and eligible dependent (if you have more than one child, you must select Family coverage)</p> <p><input type="checkbox"/> Individual & Adult - Provides coverage for two eligible adults</p> <p><input type="checkbox"/> Family - Provides coverage for up to two eligible adults and eligible dependent(s)</p> <p>A "Child" means your eligible child up to age 26. Eligibility requirements are defined in your contract.</p> <p>An "Adult" means the Spouse or Domestic Partner of the Subscriber who satisfies the eligibility requirements defined in your contract.</p> |

| 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 | | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Domestic Partner | | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Dependent 1 | | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Dependent 2 | | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Dependent 3 | | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Dependent 4 | | | | | | <input type="checkbox"/> M <input type="checkbox"/> 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: ANY PERSON WHO, WITH THE INTENT TO FRAUD 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, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

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:** _____

Signature of Agent: 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