

ENROLLMENT AND CHANGE APPLICATION

CHANGE REQUEST:
For changes, complete sections A, B, and all other applicable sections

Instructions: ALL new Employees Complete B, C, D, E, G
If your group has selected any Life Products also complete and provide your signature in F

Please type or print in black or blue, NOT RED ink

COMPLETED BY GROUP ADMINISTRATOR ONLY			
Effective Date	MM	DD	YYYY
Group Number			
Package Number			
Dept/Division/Class			

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

<p>Check All That Apply:</p> <p><input type="checkbox"/> Name Change</p> <p><input type="checkbox"/> Open Enrollment</p> <p><input type="checkbox"/> Address Change</p> <p><input type="checkbox"/> Other Insurance Information</p> <p><input type="checkbox"/> Telephone Change</p> <p><input type="checkbox"/> Replace ID Card</p> <p><input type="checkbox"/> Date of Birth Correction</p> <p><input type="checkbox"/> E-Mail Address</p> <p><input type="checkbox"/> Other _____</p>	<p>Add Dependent(s):</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Marriage</td> <td style="width: 50%;">Date of Occurrence</td> </tr> <tr> <td><input type="checkbox"/> Newborn</td> <td>MM DD YYYY</td> </tr> <tr> <td><input type="checkbox"/> Adoption</td> <td>MM DD YYYY</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td>MM DD YYYY</td> </tr> </table> <p>Remove Dependent(s):</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Marriage</td> <td style="width: 50%;">Date of Occurrence</td> </tr> <tr> <td><input type="checkbox"/> Divorce</td> <td>MM DD YYYY</td> </tr> <tr> <td><input type="checkbox"/> Student Status</td> <td>MM DD YYYY</td> </tr> <tr> <td><input type="checkbox"/> Death</td> <td>MM DD YYYY</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td>MM DD YYYY</td> </tr> </table>	<input type="checkbox"/> Marriage	Date of Occurrence	<input type="checkbox"/> Newborn	MM DD YYYY	<input type="checkbox"/> Adoption	MM DD YYYY	<input type="checkbox"/> Other	MM DD YYYY	<input type="checkbox"/> Marriage	Date of Occurrence	<input type="checkbox"/> Divorce	MM DD YYYY	<input type="checkbox"/> Student Status	MM DD YYYY	<input type="checkbox"/> Death	MM DD YYYY	<input type="checkbox"/> Other _____	MM DD YYYY	<p>Reinstate Coverage:</p> <p>Reason: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Cancel Coverage:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"><input type="checkbox"/> Not Eligible</td> <td style="width: 30%;">Date of Occurrence</td> </tr> <tr> <td><input type="checkbox"/> Left Employment</td> <td>MM DD YYYY</td> </tr> <tr> <td><input type="checkbox"/> Subscriber Request</td> <td>MM DD YYYY</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>Reason: _____</p> <p>_____</p>	<input type="checkbox"/> Not Eligible	Date of Occurrence	<input type="checkbox"/> Left Employment	MM DD YYYY	<input type="checkbox"/> Subscriber Request	MM DD YYYY	<input type="checkbox"/> Other	
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B. EMPLOYEE INFORMATION

<input type="checkbox"/> ACTIVE EMPLOYEE	<input type="checkbox"/> COBRA/STATE CONTINUATION:				
COBRA/State Continuation Qualifying Event:	<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Divorce <input type="checkbox"/> Over Age Dependent <input type="checkbox"/> Medicare Eligible				
What was the date of the Qualifying Event?	Date Continuation Started: MM DD YYYY Date Continuation Ends: MM DD YYYY				
First Name	Middle Initial	Last Name	Suffix		
Employee Social Security Number		Employee Birthdate: MM DD YYYY			
Address	Apt. No.	City	State	Zip Code	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	Height	Weight

Application Continued on Next Page →

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BlueCross BlueShield of North Carolina

Employee Name:

Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.)

Form with checkboxes for ethnicity: African American/Black, White/Caucasian, Asian/Asian American, Choose not to report, Hispanic/Latino, Native American/Alaskan Native, and Other (specify).

Company Name and Occupation fields.

Work Location, Date of Full Time Employment (MM, DD, YYYY), and Language Preference (Spanish, English, Other).

Work Phone Number, Home Phone Number, and Your E-Mail Address (optional).

C. COVERAGE SELECTION – Complete for BCBSNC Health and Dental

Coverage selection options: Blue Care (HMO), Classic Blue (CMM), Dental Blue, Blue Options (HSA/HRA, PPO), High Plan, Low Plan, and Blue Options 1-2-3.

MEDICAL BENEFITS SELECTED: Employee Only, Employee and Child(ren), Employee and Spouse, Employee and Family, No Medical Benefits.

DENTAL BENEFITS SELECTED: Employee Only, Employee and Child(ren), Employee and Spouse, Employee and Family, No Dental Benefits.

D. FAMILY INFORMATION – Complete for Anyone Taking Medical and/or Dental Coverage

- List family members taking medical or dental. Student status and handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents.

Table with columns: NAME (First, Middle Initial, Last, Suffix), Social Security Number, Marital Status, Birthdate, Sex, HEALTH, DENTAL, If Child Is Over Age 19, Please Indicate Status And School Name, Child Status (if applicable). Rows include Spouse, Domestic Partner, and Child 1, 2, 3.

*If you have more than three children, complete Section D on another application.

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH/DENTAL INSURANCE INFORMATION

E1. PRIOR HEALTH/DENTAL INSURANCE

This section MUST be completed to receive credit for prior coverage and REDUCE or ELIMINATE any applicable waiting period. See important notices regarding pre-existing condition limitations and special enrollment information attached.

Have you had any health insurance within the last sixty-three (63) days? Yes No

If YES, complete the following:

Name of Health Insurance Company and Address fields.

Employee Name:

Phone Number ()	Policy Number	Policyholder Date of Birth	MM	DD	YYYY
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Policyholder First Name	Policyholder Last Name
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If other coverage will remain in effect, write N/A in term box and complete section below.	Effective Date	MM	DD	YYYY	Termination Date or Expected Termination Date	MM	DD	YYYY
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Family Members Covered **List FIRST and LAST Names:**

Have you or any family dependents been a previous Blue Cross and Blue Shield of North Carolina member? Yes No

Names, Dates and ID Numbers

Do you have prior dental insurance? (If yes, attach a certificate of creditable coverage to this application.) Yes No

E2. OTHER HEALTH INSURANCE
*This section **MUST** be completed if you will have additional insurance in force during this new policy.*
 Will you or your covered dependents have other insurance in addition to this policy? Yes No
 Are any dependents covered under another plan due to divorce/separation? Yes No
If YES to either question, complete the following:

Name of Health Insurance Company	Policyholder First Name	Middle Initial	Last Name
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Policy Number	Policyholder Date of Birth	MM	DD	YYYY	If Individual coverage CHECK HERE <input type="checkbox"/>
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Effective Dates of Coverage: FROM: MM DD YYYY TO: MM DD YYYY

Individuals Covered (List FIRST and LAST names):

Family Members Covered by Medicare (List FIRST and LAST names):

Medicare Claim Number	Is Medicare Eligibility Due to:	Part A Effective Date:	Part B Effective Date:
	<input type="checkbox"/> Renal Disease <input type="checkbox"/> Disability <input type="checkbox"/> Age	MM DD YYYY	MM DD YYYY

F. COVERAGE SELECTION Underwritten by ■ Fort Dearborn Life Insurance Company ■ USAbLe Life (if offered by employer)

Coverage Selection:
 Your non-medical group insurance program may not include all the benefits listed below. These benefits may be underwritten by Fort Dearborn Life Insurance Company or USAbLe Life. Ask your employer for the details about these carriers, the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

Life/AD&D Yes No

Dependent Life Yes No

Weekly Disability Yes No

Long Term Disability Yes No

Supplemental Life/AD&D Yes No Amount: _____

No Benefits Selected

Employee Name:

Employee's Annual Salary				
Primary Beneficiary Name (required)		Primary Beneficiary Address (required)		
Relationship	Date of Birth	MM	DD	YYYY
Second Primary Beneficiary Name (required)		Second Primary Beneficiary Address (required)		
Relationship	Date of Birth	MM	DD	YYYY
Contingent Beneficiary Name (required)		Contingent Beneficiary Address (required)		
Relationship	Date of Birth	MM	DD	YYYY
Second Contingent Beneficiary Name (required)		Second Contingent Beneficiary Address (required)		
Relationship	Date of Birth	MM	DD	YYYY

¹ NOTE: the primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I select any of the products listed above that I will be covered by [Fort Dearborn Life Insurance Company] [or] [US Able] [at the discretion of the employer group (as indicated above)].
- I understand that if I am not actively at work as defined in the policy(ies) (for the products selected above) on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

X Signature: _____ Date MM DD YYYY

G. STATEMENT OF UNDERSTANDING

I understand that the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina and/or the life insurance carrier contract and any changes provided for therein. I understand that BCBSNC and/or the life insurance carrier may, within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, BCBSNC may take legal action at any time.

BLUE OPTIONS HSA/HRA PLANS ONLY:

I understand that if I am applying for Blue Options HSA or Blue Options HRA, the HSA/HRA is provided to me directly by a separate administrator, unaffiliated with Blue Cross and Blue Shield of North Carolina (BCBSNC). BCBSNC is not responsible or liable for administration of the HSA/HRA. Detailed information regarding my HSA/HRA will be provided by that administrator. I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.

I understand that if my employer chooses select administrators for my HSA/HRA, my employer or their designees will share certain personal information about me with such administrators to facilitate the administrator's establishment of the HSA/HRA account. By signing this application, I authorize my employer or their designees to share pertinent information with these select administrators as applicable, which may include my name, address, social security number and my employer's name.

I understand that if issued a debit card in connection with my HSA/HRA, I agree that although BCBSNC's name and marks may be included on the face of the debit card for convenience, BCBSNC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.

HSA ONLY: If I am applying for Blue Options HSA, I understand that BCBSNC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my BCBSNC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.

I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.

X Signature: _____ Date MM DD YYYY