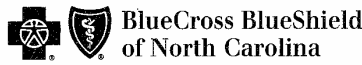


ENROLLMENT AND CHANGE APPLICATION



COMPLETED BY GROUP ADMINISTRATOR ONLY

Effective Date _____

Group Number _____

Package Number _____

Dept/Division/Class _____

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 F

PLEASE TYPE OR PRINT IN INK. PRESS FIRMLY.

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT					
CHECK ALL THAT APPLY:	ADD DEPENDENT(S):	DATE OF OCCURRENCE:	REMOVE DEPENDENT(S):	DATE OF OCCURRENCE:	CHECK ALL THAT APPLY:
	<input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Other	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Student Status <input type="checkbox"/> Death <input type="checkbox"/> Other	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	<input type="checkbox"/> ELECT COBRA EFFECTIVE COBRA QUALIFYING EVENT <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Divorce <input type="checkbox"/> Separation <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Social Security Disability Determination <input type="checkbox"/> Overaged Dependent Now Ineligible <input type="checkbox"/> Death
<input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Telephone Change <input type="checkbox"/> Replace ID card <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other Insurance Information					

B. EMPLOYEE INFORMATION					
<input type="checkbox"/> Active Employee	<input type="checkbox"/> COBRA/State Continuation: Date Continuation Started: ____/____/____	<input type="checkbox"/> Date Continuation Ends: ____/____/____			
FIRST NAME/MIDDLE INITIAL	LAST NAME	EMPLOYEE SOCIAL SECURITY #	EMPLOYEE BIRTHDATE	YOUR E-MAIL ADDRESS (optional)	
ADDRESS		APT. NO.	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	HOME PHONE NUMBER () ()	WORK PHONE NUMBER () ()
CITY	COUNTY	STATE & ZIP	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
COMPANY NAME	OCCUPATION	HIRE DATE ____/____/____	WORK LOCATION		

C. COVERAGE SELECTION: (Complete for BCBSNC Health and Dental)					
COVERAGE: (Check only one medical plan)					
<input type="checkbox"/> Blue Care® (HMO)	<input type="checkbox"/> Blue Choice® (POS)	<input checked="" type="checkbox"/> Blue Options™ (PPO)	<input type="checkbox"/> Classic Blue® (CMM)	<input type="checkbox"/> Dental Blue	
<input type="checkbox"/> Medical Benefits Selected:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Family	<input type="checkbox"/> No Medical Benefits <input type="checkbox"/> Other _____
<input type="checkbox"/> Dental Benefits Selected:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Family	<input checked="" type="checkbox"/> No Dental Benefits <input type="checkbox"/> Other _____

D. FAMILY INFORMATION - Complete for anyone taking Medical and/or Dental Coverage							
<ul style="list-style-type: none"> List family members taking medical or dental. If any dependent children are covered all children must be covered. Student status & handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents. 							
NAME (First, Middle Initial, Last)	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	HEALTH	DENTAL	IF CHILD IS OVER AGE 19, PLEASE INDICATE STATUS AND SCHOOL NAME	CHILD STATUS if applicable
SPOUSE			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
CHILD 1			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-time Student at: _____	<input type="checkbox"/> Foster ¹ <input type="checkbox"/> Adopted ¹
CHILD 2			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-time Student at: _____	<input type="checkbox"/> Foster ¹ <input type="checkbox"/> Adopted ¹
CHILD 3			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-time Student at: _____	<input type="checkbox"/> Foster ¹ <input type="checkbox"/> Adopted ¹

¹ Please attach additional documentation required (see instructions). If you have more than three children, please complete Section D on another application.

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION			
E1. Prior Health Insurance			
This section MUST be completed to receive credit for prior coverage and REDUCE or ELIMINATE any applicable waiting period.			BCBSNC will assist in obtaining a certificate of coverage from any prior plan or issuer, if necessary.
Have you had any Health Insurance within the last 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, complete below			
NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY		POLICY NUMBER	
POLICYHOLDER AND DATE OF BIRTH	EFFECTIVE DATE	TERMINATION DATE OR EXPECTED TERMINATION DATE	
____/____/____	____/____/____	____/____/____	
<small>If other coverage will remain in effect write N/A in term box, and complete section below.</small>			

Application is continued on reverse side →

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION *continued*

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

IF YES TO EITHER QUESTION, complete E2 below

Are any dependents covered under another plan due to divorce/separation? Yes No

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY		POLICY HOLDER NAME AND DATE OF BIRTH	
POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE		If Individual coverage check here <input type="checkbox"/>	POLICY HOLDER SOCIAL SECURITY NUMBER
POLICY NUMBER	EFFECTIVE DATES OF COVERAGE From: _____ To: _____		
INDIVIDUALS COVERED		FAMILY MEMBERS COVERED BY MEDICARE	
MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO: <input type="checkbox"/> RENAL DISEASE <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY		PART A EFFECTIVE DATE ____/____/____
			PART B EFFECTIVE DATE ____/____/____

F. COVERAGE SELECTION Medical Life Insurance Company USable Life underwrites - Life, AD & D, Disability (if offered by employer)

Coverage Selection: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

LIFE/AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENT LIFE <input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	LONG TERM DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	SUPPLEMENTAL LIFE/AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO AMOUNT _____	<input type="checkbox"/> NO BENEFITS SELECTED
EMPLOYEE SALARY _____ <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUAL					
PRIMARY BENEFICIARY NAME AND ADDRESS (REQUIRED)		RELATIONSHIP	D.O.B.	SOCIAL SECURITY NUMBER	%
CONTINGENT BENEFICIARY NAME AND ADDRESS (REQUIRED)		RELATIONSHIP	D.O.B.	SOCIAL SECURITY NUMBER	%
<ul style="list-style-type: none">I understand that if I select Life that I will be covered by Medical Life Insurance Company or USable Life 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 (coverage listed in Section D of this application) 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 _____					

G. STATEMENT OF UNDERSTANDING AND AUTHORIZATION

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 authorize any medical professional, medical care institution, or other provider of health care services or supplies to furnish to BCBSNC information concerning services or supplies provided to me or any family member. I understand that this information will be used for the purposes of determining eligibility for coverage, review, investigation, or payment of a claim and review of records for quality improvement initiatives. Such records may be reviewed by third party quality review organizations. I authorize any prior insurance carrier to furnish information concerning my and/or my dependents prior insurance coverage provided me and my eligible family members. The authorization is valid for 30 months from the date of this signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with review of claims.

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.

I understand that personal information may be collected from persons other than me or my dependents, and personal and privileged information collected by BCBSNC and/or the life insurance carrier may, in certain circumstances, be disclosed to others without my authorization. I understand that I have the right to access and correct any defects in information collected, and that I may obtain a more detailed explanation of this notice upon request to BCBSNC.

I understand that in the course of its business operations BCBSNC and/or the life insurance carrier obtains personal information about me and my dependents, and use this information for the administration of the plan(s). I further understand that in certain situations this information may need to be disclosed to others, including contractors working on behalf of BCBSNC or the life insurance carrier I hereby consent to these disclosures as permitted or required by law and as set forth in the BCBSNC member Confidentiality Policy. In particular, I consent to disclosures by BCBSNC and the life insurance carrier: in connection with treatment, payment, health care operations as authorized by law, coordination of care, quality assessment and measurement and accreditation. I also consent to disclosures authorized by the North Carolina Insurance Information Privacy Protection act (the "Act"), including but not limited to those that are reasonably necessary to allow the performance of business, professional or insurance functions on behalf of the Plan(s), those made to detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction, those made to insurance regulatory authorities, and those made in response to an administrative or judicial order, or a subpoena. I further recognize that there are certain disclosures for which the law does not require my consent, and that these disclosures may be made by BCBSNC and/or the life insurance carrier as permitted or required by law.

I also consent to disclosures of information to my employer, in connection with their administration of the employee health benefits plan.

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 Employee Signature _____ Date _____