# ENROLLMENT AND CHANGE APPLICATION

BlueCross BlueShield of North Carolina

| 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: | |
|---|---|---|---|---|---|---|
| ☐ Name Change | ☐ Marriage | | ☐ Marriage | | ☐ ELECT COBRA EFFECTIVE _____ | ☐ CANCEL COVERAGE |
| ☐ Address Change | ☐ Newborn | | ☐ Divorce | | **COBRA QUALIFYING EVENT** | REINSTATE COVERAGE: |
| ☐ Telephone Change | ☐ Adoption | | ☐ Student Status | | ☐ Termination of Employment | ☐ Return from Layoff |
| ☐ Replace ID card | ☐ Other | | ☐ Death | | ☐ Reduction in Hours | ☐ Return from Leave |
| ☐ Date of Birth Correction | _____ | | ☐ Other | | ☐ Divorce ☐ Separation | ☐ Retirement |
| ☐ Open Enrollment | | | _____ | | ☐ Medicare Eligible | ☐ Disenrollment Error |
| ☐ Other Insurance Information | | | | | ☐ Social Security Disability Determination | ☐ Other |
| | | | | | ☐ Overaged Dependent Now Ineligible | _____ |
| | | | | | ☐ Death | _____ |

## B. EMPLOYEE INFORMATION

☐ Active Employee ☐ COBRA/State Continuation: Date Continuation Started: ___/___/___ ☐ Date Continuation Ends: ___/___/___

| FIRST NAME/MIDDLE INITIAL | LAST NAME | EMPLOYEE SOCIAL SECURITY # | EMPLOYEE BIRTHDATE | YOUR E-MAIL ADDRESS *(optional)* |
|---|---|---|---|---|
| | | | | |

| ADDRESS | APT. NO. | ☐ FEMALE ☐ MALE | HOME PHONE NUMBER ( ) | WORK PHONE NUMBER ( ) |
|---|---|---|---|---|
| | | | | |

| CITY | COUNTY | STATE & ZIP | MARITAL STATUS |
|---|---|---|---|
| | | | ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED |

| COMPANY NAME | OCCUPATION | HIRE DATE | WORK LOCATION |
|---|---|---|---|
| | | ___/___/___ | |

## C. COVERAGE SELECTION: (Complete for BCBSNC Health and Dental)

**COVERAGE:** *(Check only one medical plan)* ☐ Blue Care® (HMO) ☐ Blue Choice® (POS) ☒ Blue Options℠ (PPO) ☐ Classic Blue® (CMM) ☐ Dental Blue

☐ **Medical Benefits Selected:** ☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Employee and Family ☐ No Medical Benefits ☐ Other _____

☐ **Dental Benefits Selected:** ☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Employee and Family ☒ No Dental Benefits ☐ Other _____

## D. FAMILY INFORMATION - Complete for anyone taking Medical and/or Dental Coverage

- 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 | | | ☐ FEMALE ☐ MALE | ☐ YES ☐ NO | ☐ YES ☐ NO | | |
| CHILD 1 | | | ☐ FEMALE ☐ MALE | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ Handicapped ☐ Full-time Student at: _____ | ☐ Foster[1] ☐ Adopted[1] |
| CHILD 2 | | | ☐ FEMALE ☐ MALE | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ Handicapped ☐ Full-time Student at: _____ | ☐ Foster[1] ☐ Adopted[1] |
| CHILD 3 | | | ☐ FEMALE ☐ MALE | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ Handicapped ☐ Full-time Student at: _____ | ☐ Foster[1] ☐ 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.

Have you had any Health Insurance within the last 63 days? ☐ Yes ☐ No **IF YES, complete below**

***BCBSNC will assist in obtaining a certificate of coverage from any prior plan or issuer, if necessary.***

| NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY | POLICY NUMBER |
|---|---|
| | |

| POLICYHOLDER AND DATE OF BIRTH | EFFECTIVE DATE | TERMINATION DATE OR EXPECTED TERMINATION DATE | If other coverage will remain in effect write N/A in term box, and ⬅ complete section below. |
|---|---|---|---|
| ___/___/___ | ___/___/___ | | |

*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

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

***IF YES TO EITHER QUESTION, complete E2 below***

| 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 ☐ | 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: | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE |
|---|---|---|---|
| | ☐ RENAL DISEASE ☐ AGE ☐ DISABILITY | / / | / / |

## 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 | DEPENDENT LIFE | WEEKLY DISABILITY | LONG TERM DISABILITY | SUPPLEMENTAL LIFE/AD&D | ☐ NO BENEFITS SELECTED |
|---|---|---|---|---|---|
| ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO AMOUNT _____ | |

EMPLOYEE SALARY _____ ☐ WEEKLY ☐ MONTHLY ☐ 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 | % |
| | | | | |

- 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.**

XEmployee Signature _____ Date _____