Enrollment and Change Application

Instructions:

- All employees complete Sections **B**, **C**, **D**, **E**, **G** and **H**.
- For change requests, complete Sections **A**, **B** and all other applicable sections.
- If your group has elected USAble Life products you must complete Section **F**.

  For USAble Life Only coverage: If you are a late applicant or applying for over the guarantee issue amount complete Sections **A**, **B**, **F** and **H** to their entirety.

Completed by Group Administrator Only
Group Number
Life Class Designation (if applicable):

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

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

Check All That Apply:

- ☐ Name
- ☐ Address
- ☐ Other Insurance Information
- ☐ Telephone
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ E-Mail Address
- ☐ Late Applicant
- ☐ Over the Guarantee Issue
- ☐ Other _____

Add Dependent(s): Date of Occurrence (mm dd yyyy)

- ☐ Marriage
- ☐ Newborn
- ☐ Adoption
- ☐ Other _____

Remove Dependent(s): Date of Occurrence (mm dd yyyy)

- ☐ Marriage
- ☐ Divorce
- ☐ Dependent Age
- ☐ Death
- ☐ Other _____

Reinstate Coverage:

Reason: _____

Cancel Coverage: Date of Occurrence (mm dd yyyy)

- ☐ Not Eligible
- ☐ Left Employment
- ☐ Subscriber Request
- ☐ Other

Reason: _____

B. EMPLOYEE INFORMATION

☐ ACTIVE EMPLOYEE ☐ COBRA/STATE CONTINUATION

COBRA/State Continuation Qualifying Event: ☐ Termination of Employment ☐ Reduction in Hours ☐ Death of Subscriber ☐ Divorce ☐ Over Age Dependent ☐ Medicare Eligible

What was the date of the Qualifying Event? (mm dd yyyy) Date Continuation Started (mm dd yyyy) Date Continuation Ends (mm dd yyyy)

First Name	Middle Initial	Last Name	Suffix

Address *(If selecting Blue Options HSA or HRA, you must provide a street address not a P.O. Box)*	Apt. No.	City	State	Zip Code

Employee Social Security Number	Employee Birthdate (mm dd yyyy)	☐ Male ☐ Female	Marital Status

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.)

☐ African American/Black ☐ Asian/Asian American ☐ Choose not to report
☐ White/Caucasian ☐ Hispanic/Latino ☐ Native American/Alaskan Native ☐ Other (specify) _____

Company Name	Occupation

Work Location	Date of Full Time Employment (mm dd yyyy)	Language Preference ☐ Spanish ☐ English ☐ Other _____

Home Phone Number	Work Phone Number	E-Mail Address
( )	( )	

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BlueCross BlueShield of North Carolina

Employee Name:

C. BENEFITS AND COVERAGE SELECTION – Complete for BCBSNC Health and Dental, if offered by employer

MEDICAL PLAN: ☐ No Medical Coverage ☐ Blue Options HSA℠ ☐ Blue Care® (HMO) ☐ Blue Options PPO ☐ Classic Blue® (CMM) ☐ Blue Options 1-2-3 ☐ Blue Options HRA℠ ☐ High ☐ Low

MEDICAL COVERAGE (if applicable): ☐ Employee Only ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Employee/Family

DENTAL PLAN: ☐ No Dental Coverage ☐ Dental

DENTAL COVERAGE (if applicable): ☐ Employee Only ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Employee/Family

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

NAME First, Middle Initial, Last, Suffix	Social Security Number	Birthdate mm/dd/yyyy	Sex	HEALTH	DENTAL	Child Status (please check one)
Spouse	required		☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
Child 1			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	☐ Foster ☐ Adopted ☐ Handicapped** ☐ Under the age of 26***
Child 2			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	☐ Foster ☐ Adopted ☐ Handicapped** ☐ Under the age of 26***
Child 3**			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	☐ Foster ☐ Adopted ☐ Handicapped** ☐ Under the age of 26***

* Application does not guarantee enrollment.
** A request for coverage (form P24) is required if your child is 26 years or older and will be reviewed to determine eligibility.
*** Consult your employer regarding dependent eligibility requirements. Supporting documentation may be required.
**** If you have more than three children, complete **Section D** on another application.

E. OTHER HEALTH/DENTAL INSURANCE INFORMATION

Have you or your dependents had any other health or dental coverage within the last 12 months (other than BCBSNC coverage that you are applying for today)? ☐ Yes ☐ No

See important notices regarding pre-existing condition limitations and special enrollment information attached.
Please list any health or dental coverage the employee and/or dependents has/had within the last 12 months (including BCBSNC coverage):

Insurance Carrier | Policy Number

Policy Holder Name | Date of Birth mm dd yyyy

Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group ☐ Medical ☐ Dental (Proof of dental coverage must be included with application for processing)

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Additional Dependents

Additional Coverage that will be in-force when this policy becomes active:

Insurance Carrier | Policy Number

Policy Holder Name | Date of Birth mm dd yyyy

Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group ☐ Medical ☐ Dental (Proof of dental coverage must be included with application for processing)

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Additional Dependents

Additional Coverage that will be in-force when this policy becomes active:

Insurance Carrier | Policy Number

Policy Holder Name | Date of Birth mm dd yyyy

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Employee Name:

Effective Date mm dd yyyy	Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group ☐ Medical ☐ Dental (Proof of dental coverage must be included with application for processing)

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Additional Dependents

If anyone covered has Medicare Coverage please complete below:

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Additional Dependents

Medicare Claim Number:	Eligible Due To: ☐ Renal Disease First Day of Dialysis mm dd yyyy ☐ Disability ☐ Age
Part A Effective Date: mm dd yyyy	Part B Effective Date: mm dd yyyy

F. COVERAGE SELECTION FOR PRODUCTS UNDERWRITTEN BY USAble LIFE, if offered by employer

USAble Life is an independent life insurance company that does not provide BCBSNC products or services. USAble Life is solely responsible for the life and disability insurance coverage below. Your non-medical group insurance program may not include all the benefits listed below. These benefits will be written by USAble Life. Ask your employer details. Employer is required to retain a copy of this form for beneficiary information.

Life/AD&D ☐ **Yes** ☐ **No**
Dependent Life ☐ **Yes** ☐ **No**
Weekly Disability ☐ **Yes** ☐ **No**
Long Term Disability ☐ **Yes** ☐ **No**
Supplemental Life/AD&D ☐ **Yes** ☐ **No**

Change to Supplemental Life/AD&D Amount: _____

☐ **No Benefits Selected**

Employee's Annual Salary (Required If Salary Based Plan)	Employee's Job Title

Primary Beneficiary Name **(required)**		Primary Beneficiary Address **(required)**	
Relationship	Date of Birth mm dd yyyy	Social Security Number	Percent[1]
Second Primary Beneficiary Name **(required)**		Second Primary Beneficiary Address **(required)**	
Relationship	Date of Birth mm dd yyyy	Social Security Number	Percent[1]
Contingent Beneficiary Name **(required)**		Contingent Beneficiary Address **(required)**	
Relationship	Date of Birth mm dd yyyy	Social Security Number	Percent[1]
Second Contingent Beneficiary Name **(required)**		Second Contingent Beneficiary Address **(required)**	
Relationship	Date of Birth mm dd yyyy	Social Security Number	Percent[1]

[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 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(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

LIFE INSURABILITY QUESTIONNAIRE Complete only if you are a late applicant or applying for coverage over the guarantee issue amount

1. Employee Height:	2. Employee Weight:

	Yes	No
3. Have you used any tobacco products in the past year?	☐	☐
4. Do you have any condition for which consultation or treatment is contemplated or has been advised?	☐	☐
5. Have you been hospitalized for any reason during the past five (5) years?	☐	☐
6. Have you consulted a physician in the past one (1) year for any reason?	☐	☐

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Employee Name:

7. Have you ever been diagnosed or treated by a member of the medical profession for:

	Yes	No
a. Cancer, cancer related disease or benign tumor?	☐	☐
b. Disease of the heart or blood vessels, or had a stroke?	☐	☐
c. Kidney disease or diabetes?	☐	☐
d. Alcohol or drug abuse?	☐	☐
e. Lung, asthma, liver or blood disorder?	☐	☐
f. Emotional, nervous system, eating disorder, or mental health problems?	☐	☐
g. Ulcer, stomach or digestive disorder?	☐	☐
h. Arthritis, back, bones or joint disorder?	☐	☐
i. Bladder, urinary system or reproductive organs disorder?	☐	☐

	Yes	No
8. Have you ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")?	☐	☐
9. Have you ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? If yes, list name of person(s), medications taken, medication dosage, and last two blood pressure readings.	☐	☐
10. Are you currently taking medication(s)? If yes, list name of person, medications and dosage.	☐	☐
11. Have you ever had any impairments, diseases or illnesses not covered in questions 2-8?	☐	☐
12a. Are you now pregnant? ☐ Yes ☐ No		
12b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?	☐	☐
13. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If no, give full details.	☐	☐

14. Names, addresses, and phone numbers of the personal physicians of all applicants:

G. STATEMENT OF UNDERSTANDING

I understand that the benefits for which I (we) will be eligible are those described in the BCBSNC and/or the USAble Life contract and any changes provided for therein. I further understand that BCBSNC and/or USAble Life 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 with regard to your medical insurance.

I understand that if I am applying for Blue Options HSA and my employer has established an HSA, the HSA will be 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.

I understand that if I am applying for Blue Options HRA and my employer has established an HRA, the HRA may be administered by BCBSNC separately from my health insurance plan, or by a separate administrator.

Detailed information regarding my HSA/HRA will be provided by the designated 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 establishes an HSA/HRA, my employer or their designees will share certain personal information about me with these 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 selected 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

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Employee Name:

H. STATEMENT OF AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that if I refuse to sign this authorization that BCBSNC and/or USAble Life may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC and/or USAble Life.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

(i) my past, present, or future physical or mental health or condition;

(ii) the provision of health care to me; or

(iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to BCBSNC and/or USAble Life.

I further authorize BCBSNC and/or USAble Life to review any applications for health care coverage that I may have submitted to BCBSNC and/or USAble Life in the past.

I authorize BCBSNC and/or USAble Life to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that BCBSNC and/or USAble Life will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that BCBSNC and/or USAble Life will make every effort to safeguard my protected health information. I further understand that BCBSNC and/or USAble Life will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require BCBSNC and/or USAble Life to disclose my protected health information. I understand that BCBSNC and/or USAble Life may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

Rating
Blue Cross and Blue Shield of North Carolina
P.O. Box 30013
Durham, NC 27702

USAble Life
320 West Capital Avenue
Suite 700
Little Rock, Arkansas 72201

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

(i) for information that BCBSNC and/or USAble Life already used or disclosed, relying on this authorization or

(ii) if the authorization was obtained as a condition of coverage in BCBSNC and/or USAble Life and, by law, BCBSNC and/or USAble Life has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below. After 120 days expire, BCBSNC and/or USAble Life may no longer use this information.

Signature of Primary Applicant or Legal Personal Representative: **X** _____ Date mm dd yyyy

Name of Legal Personal Representative and Relationship to Primary Applicant (please print): _____ Date mm dd yyyy