



NEW ENROLLEE
(Please complete A, C, D, E, F and G)

CHANGE REQUEST
(For changes, complete Sections A, B and all other applicable sections)

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

Completed By Group Administrator Only
Group Number (if applicable):
Blue Cross NC Subscriber ID Number (if applicable):

A. Employee Information:

Social Security Number:		Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last Name:		First Name:		MI:	
Mailing Address:		City:	State:	Zip Code:	County:
P.O. Box (For Blue Options HSA / HSA eligible plans you must also provide a street address.):		City:	State:	Zip Code:	
Company Name:		Occupation:			
Work Location:		Date of Full Time Employment:		<input type="text" value="mm"/>	<input type="text" value="dd"/>
Language Preference: <input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other: _____					
Home Phone Number: ()		Work Phone Number: ()		E-Mail Address:	
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.)					
<input type="checkbox"/> African American / Black <input type="checkbox"/> Asian / Asian American <input type="checkbox"/> American Indian / Alaska Native					
<input type="checkbox"/> White / Caucasian <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Choose not to report <input type="checkbox"/> Other (specify): _____					
<input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA / State Continuation <input type="checkbox"/> Retiree (51+)					

B. If Enrolling in COBRA / State Continuation Qualifying Life Event (QLE):

<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Medicare Eligible					
<input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Over Age Dependent					
What was the date of the Qualifying Life Event?		Date Continuation Started:		Date Continuation Ends:	
<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>

Employee Name:

C. If Enrolling Due to a Qualifying Life Event:

You may apply for coverage for yourself or a dependent outside of open enrollment due to a qualifying life event within 30 days of the date of the event (unless 60 days is required by law). (Legal documentation may be required.) Please fill out this section unless otherwise instructed by your Group Administrator.

Adding a Dependent due to:

Marriage

mm	dd	yyyy
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Birth

mm	dd	yyyy
----	----	------

Adoption

mm	dd	yyyy
----	----	------

Date of Occurrence

Foster Placement

mm	dd	yyyy
----	----	------

Court Order

mm	dd	yyyy
----	----	------

Other: _____

mm	dd	yyyy
----	----	------

Date of Occurrence

Enrolling and/or adding a dependent due to loss of other coverage as a result of:

Exhaustion of COBRA Continuation

mm	dd	yyyy
----	----	------

Divorce

mm	dd	yyyy
----	----	------

Loss of dependent status

mm	dd	yyyy
----	----	------

Death

mm	dd	yyyy
----	----	------

Reduction in hours

mm	dd	yyyy
----	----	------

Termination of other coverage

mm	dd	yyyy
----	----	------

Date of Occurrence

Termination of employment

mm	dd	yyyy
----	----	------

Offered plan is no longer in your service area

mm	dd	yyyy
----	----	------

Discontinuance of other coverage

mm	dd	yyyy
----	----	------

Termination of employer contributions toward coverage

mm	dd	yyyy
----	----	------

Meeting or exceeding the lifetime benefit maximum of other plan

mm	dd	yyyy
----	----	------

Date of Occurrence

If either of the following events occurred, you or your dependent(s) may apply within 60 days of the date of the event. Please indicate the event that applies to you and/or your dependent(s):

Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)

mm	dd	yyyy
----	----	------

Gain eligibility for premium payment assistance from Medicaid or the Children's Health Insurance Program (CHIP)

mm	dd	yyyy
----	----	------

What was the date of the Qualifying Life Event?

D. If Making a Change from Previous Enrollment

Check All That Apply:

Name (Legal documentation is required.) Other Insurance Information Date of Birth Correction (Legal documentation may be required.) E-Mail Address

Address Phone Number Replace ID Card Other: _____

Remove Dependent(s):

Divorce

mm	dd	yyyy
----	----	------

Death

mm	dd	yyyy
----	----	------

Dependent Age

mm	dd	yyyy
----	----	------

Other: _____

mm	dd	yyyy
----	----	------

Date of Occurrence

Reason: _____

Employee Name:

Cancel Coverage:

Not Eligible

mm	dd	yyyy
----	----	------

Subscriber Request
(Open Enrollment Only)

mm	dd	yyyy
----	----	------

Left
Employment

mm	dd	yyyy
----	----	------

Other: _____

mm	dd	yyyy
----	----	------

Date of Occurrence

Date of Occurrence

Reason: _____

Reinstate Coverage:

Reason: _____

E. Benefits and Coverage Selection – Complete for Blue Cross NC Health, Dental and Vision, if Offered by Employer

Blue High Performance NetworkSM (EPO)^{***}

Classic Blue[®] (CMM)

Blue High Performance NetworkSM (1-2-3 plan design) (EPO)^{***}

Dental Blue[®]

Blue Options[®] 1-2-3SM (PPO)

Dental Blue[®] SelectSM

Blue Options[®] HSASM

Dental Blue[®] PreferredSM

Blue Options[®] (PPO)

Blue 20/20SM Vision

Blue Care[®] (HMO)

No
Medical
Coverage

Small Group Fully-Insured

******* I understand that the plan selected has a national provider network limited to Blue High Performance Network. I certify that I live in one of the North Carolina approved High Performance Network (BlueHPN) Markets / Product Areas. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network and I will receive out-of-network coverage for urgent, emergent care or ambulance services, and for medically necessary covered services when an in-network provider is not reasonably available per Blue Cross NC's access to care standards. Non-participating urgent care services inside the BlueHPN product area are not covered.

20+ Balance Funded / 75+ Self Funded / 51+ Fully-Insured

******* I understand that the plan selected has a national provider network limited to Blue High Performance Network. I certify that I live in one of the approved High Performance Network (BlueHPN) Markets / Product Areas. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network and I will receive out-of-network coverage for urgent, emergent care or ambulance services, and for medically necessary covered services when an in-network provider is not reasonably available per Blue Cross NC's access to care standards. Non-participating urgent care services inside the BlueHPN product area are not covered.

1000+ Self Funded Only

******* I understand that the plan selected has a national provider network limited to Blue High Performance Network. I certify that I live or work in one of the approved High Performance Network (BlueHPN) Markets / Product Areas. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network and I will receive out-of-network coverage for urgent, emergent care or ambulance services, and for medically necessary covered services when an in-network provider is not reasonably available per Blue Cross NC's access to care standards. Non-participating urgent care services inside the HPN product area are not covered.

I can search for a provider in the online "find a doctor" tool to determine if my provider is in my plan's network. I acknowledge that I have the right to decline my employer's coverage and enroll in different coverage outside of the coverage offered by my employer.

Employee Name:

HEALTH COVERAGE (if applicable):

Employee Only Employee / Spouse / Domestic Partner Employee / Child(ren) Employee / Family

If your group is offering multiple plans,
please enter plan name selected: _____

DENTAL PLAN:

Dental No Dental Coverage

If your group is offering multiple plans,
please enter plan name selected: _____

DENTAL COVERAGE (if applicable):

Employee Only Employee and Spouse and Child Employee / Spouse / Domestic Partner
 Employee and Dependent Employee and Child Employee / Children Employee / Family

BLUE 20/20SM VISION COVERAGE (if applicable):

Employee Only Employee and Spouse and Child Employee / Spouse / Domestic Partner
 Employee and Dependent Employee and Child Employee / Children Employee / Family

DECLINE MEDICAL COVERAGE:

Check one only: I am rejecting Employee Coverage I am rejecting Dependent / Spouse Coverage

Declining coverage for the following reason (check one):

Another plan offered by my employer

COBRA or State Continuation

A government plan (type): _____

An individual plan

My spouse's group coverage

Other (explain): _____

I and/or my dependents are not covered by any other health benefit plan

Names of any dependents rejecting coverage: _____

I understand that if I elect to apply for coverage for myself, my spouse / domestic partner, and/or my dependent child(ren) through this employer health plan at a later time, I may be delayed until the employer's open enrollment period.

Important Notice of Special Enrollment:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance (including Medicaid or Children's Health Insurance Program (CHIP)) or group health plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.

Signature of Primary Applicant: **X** _____

Date

mm

dd

yyyy

Employee Name:

F. Family Information – Legal Documentation May be Required

Health	Dental	Blue 20/20 Vision	Name (First, Middle Initial, Last, Suffix)	Social Security Number (Required for Spouse / Domestic Partner)	Birthdate (mm/dd/yyyy)	Gender	Child Status (please check if applicable)
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			<input type="checkbox"/> M <input type="checkbox"/> F	N/A
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Child 1			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Intellectually or physically disabled
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Child 2			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Intellectually or physically disabled
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Child 3			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Intellectually or physically disabled

* Application does not guarantee enrollment.

** If you have more than three children, complete an Additional Dependent form.

Additional Dependent form attached.

Dependent children include foster, adopted or a child placed by court or administrative order.

G. Other Health Insurance Information

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

Insurance Carrier:	Policy Holder Name:	Policy Number:
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Date of Birth:	Effective Date:	Termination Date or Expected Termination Date:
<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/>
mm	dd	yyyy
mm	dd	yyyy
mm	dd	yyyy

(If remaining active leave blank)

What kind of coverage? Individual Group

Persons covered:

Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

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

Insurance Carrier:	Policy Holder Name:	Policy Number:
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Date of Birth:	Effective Date:	Termination Date or Expected Termination Date:
<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/>
mm	dd	yyyy
mm	dd	yyyy
mm	dd	yyyy

(If remaining active leave blank)

What kind of coverage? Individual Group

Persons covered:

Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

Employee Name:

If anyone covered has Medicare Coverage please complete below:

Persons covered:

Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

Medicare Claim Number:

Medicare C Yes No

If yes,
Carrier's Name: _____

Eligible Due To:

Renal Disease; First Day of Dialysis:

Where does dialysis take place? Home Center;

Kidney Transplant? Yes No

Disability; Is the member actively working? Yes No

Age

Part A Effective Date:

Part B Effective Date:

H. Other Dental Insurance Information

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

See important notices regarding special enrollment information attached. Please list any dental coverage the employee and/or dependents has/had within the last 12 months (including Blue Cross NC coverage): (To receive prior dental credit against this group benefit plan, please list prior dental coverage within the last 12 months.) Blue Cross NC may request a certificate of creditable coverage for verification purposes.

Insurance Carrier:

Policy Holder Name:

Policy Number:

Date of Birth:

Effective Date:

Termination Date or Expected Termination Date:

(If remaining active leave blank)

What kind of coverage? Individual Group

Persons covered:

Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

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

Insurance Carrier:

Policy Holder Name:

Policy Number:

Date of Birth:

Effective Date:

Termination Date or Expected Termination Date:

(If remaining active leave blank)

What kind of coverage? Individual Group

Persons covered:

Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

Employee Name:

I. Statement of Understanding / Legal Notices – Your Signature is Required

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross NC (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that Blue Cross NC may, within two years of the date of this application, rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. If fraudulent misstatements were made, Blue Cross NC may take legal action at any time.

I understand that if I am applying for Blue Options HSA or an HSA eligible plan and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with Blue Cross NC. Blue Cross NC is not responsible or liable for administration of the HSA.

I understand that if I am applying for a medical plan paired with an HRA and my employer has established an HRA, the HRA may be administered by Blue Cross NC 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 Blue Cross NC's name and marks may be included on the face of the debit card for convenience, Blue Cross NC 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 or an HSA eligible plan, I understand that Blue Cross NC 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 Blue Cross NC 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.

Notice of Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

For questions or to obtain more information, contact a Blue Cross NC Customer Service Representative at: **Blue Cross NC Customer Service, Blue Cross and Blue Shield of North Carolina, PO Box 2291, Durham, NC 27702, 1-877-258-3334** (toll-free).

By signing below, I agree to the above Statement of Understanding and have read all of the Legal Notices.

Signature of Primary Applicant: **X**

mm	dd	yyyy
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Date

