BlueCross BlueShield of North Carolina

Visit us at **BlueCrossNC.com**

Enrollment / Change Application

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

☐ **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

A. Employee Information:

Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ 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: mm dd yyyy			

Language Preference: ☐ Spanish ☐ English ☐ 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.)

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

☐ Active Employee ☐ COBRA / State Continuation ☐ Retiree (51+)

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

☐ Termination of Employment ☐ Divorce ☐ Death of Subscriber ☐ Medicare Eligible
☐ Reduction in Hours ☐ Over Age Dependent

What was the date of the Qualifying Life Event?	Date Continuation Started:	Date Continuation Ends:
mm dd yyyy	mm dd yyyy	mm dd 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
- ☐ 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)
- ☐ 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
- ☐ Dependent Age — mm / dd / yyyy

Date of Occurrence

- ☐ Death — mm / dd / yyyy
- ☐ Other: _____ — mm / dd / yyyy

Date of Occurrence

Reason: _____

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Employee Name:

Cancel Coverage:

☐ Not Eligible — mm / dd / yyyy

☐ Left Employment — mm / dd / yyyy

Date of Occurrence

☐ Subscriber Request (Open Enrollment Only) — mm / dd / yyyy

☐ Other: _____ — mm / dd / yyyy

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 Network℠ (EPO)***
- ☐ Blue High Performance Network℠ (1-2-3 plan design) (EPO)***
- ☐ Blue Options® 1-2-3℠ (PPO)
- ☐ Blue Options® HSA℠
- ☐ Blue Options® (PPO)
- ☐ Blue Care® (HMO)
- ☐ Classic Blue® (CMM)
- ☐ Dental Blue®
- ☐ Dental Blue® Select℠
- ☐ Dental Blue® Preferred℠
- ☐ Blue 20/20℠ Vision
- ☐ 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.

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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 20/20℠ 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

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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)
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Spouse ☐ Domestic Partner			☐ M ☐ F	N/A
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Child 1			☐ M ☐ F	☐ Intellectually or physically disabled
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Child 2			☐ M ☐ F	☐ Intellectually or physically disabled
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	Child 3			☐ M ☐ F	☐ 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:

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

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:

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

Persons covered:
☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

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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: mm dd yyyy Where does dialysis take place? ☐ Home ☐ Center;

☐ Kidney Transplant? ☐ Yes ☐ No

☐ Disability; Is the member actively working? ☐ Yes ☐ No

☐ Age

Part A Effective Date: mm dd yyyy Part B Effective Date: mm dd yyyy

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

<u>See important notices regarding special enrollment information attached.</u> 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: 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

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: 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

Persons covered:
☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

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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

Date

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Employee Name:

J. Statement of Authorization for Release of Protected Health Information – Your Signature is Required

I understand that if I refuse to sign this authorization that Blue Cross NC may refuse to enroll me or determine that I am not eligible for benefits in Blue Cross NC.

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, pharmacy benefit manager or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to Blue Cross and Blue Shield of North Carolina ("Blue Cross NC").

I further authorize Blue Cross NC to review any applications for health care coverage that I may have submitted to Blue Cross NC in the past.

I authorize Blue Cross NC 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 Blue Cross NC will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that Blue Cross NC will make every effort to safeguard my protected health information. I further understand that Blue Cross NC will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require Blue Cross NC to disclose my protected health information. I understand that Blue Cross NC 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:

Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702-2291

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 Blue Cross NC already used or disclosed, relying on this authorization or
(ii) if the authorization was obtained as a condition of coverage in Blue Cross NC and, by law, Blue Cross NC 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.

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

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

A photographic copy of this authorization shall be as valid as the original.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el everso de su tarjeta del seguro para obtener ayuda.