

ENROLLMENT AND CHANGE APPLICATION *with health questions*

Instructions:

- ALL employees complete Sections **B, C, D, E, G** (if applicable), **I** and **J**.
 - For change requests, complete Sections **A, B** and all other applicable sections.
 - If your group has also elected US Able Life products you must complete Section **H**.
- For US Able Life Only coverage:** If you are a late applicant or applying for over the guaranteed issue amount complete Sections **A, B, G, H, I** and **J** in their entirety.

Completed by Group Administrator Only			
Effective Date	MM	DD	YYYY
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: <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Other Insurance Information <input type="checkbox"/> Telephone <input type="checkbox"/> Replace ID Card <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> E-Mail Address <input type="checkbox"/> Late Applicant <input type="checkbox"/> Over the Guarantee Issue <input type="checkbox"/> Other _____	Add Dependent(s): <input type="checkbox"/> Marriage Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Newborn Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Adoption Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Other _____ Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div>	Reinstate Coverage: Reason: _____ _____ _____
	Remove Dependent(s): <input type="checkbox"/> Marriage Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Divorce Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Dependent Age Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Death Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Other _____ Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div>	Cancel Coverage: <input type="checkbox"/> Not Eligible Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Left Employment Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Subscriber Request Date of Occurrence <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div> <input type="checkbox"/> Other Reason: _____ _____ _____

B. EMPLOYEE INFORMATION

<input type="checkbox"/> ACTIVE EMPLOYEE	<input type="checkbox"/> COBRA/STATE CONTINUATION				
COBRA/State Continuation Qualifying Event:	<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Divorce <input type="checkbox"/> Over Age Dependent <input type="checkbox"/> Medicare Eligible				
What was the date of the Qualifying Event?	Date Continuation Started Date Continuation Ends <div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div>				
First Name	Middle Initial	Last Name	Suffix		
Address		Apt. No.	City	State	Zip Code
<i>(If selecting Blue Options HSA or HRA, you must provide a street address not a P.O. Box)</i>					
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"/> Choose not to report <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Other (specify) _____					
Company Name			Occupation		
Work Location	Date of Full Time Employment	Language Preference			
	<div style="border: 1px solid black; padding: 2px; display: inline-block;">MM</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DD</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">YYYY</div>	<input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other _____			
Work Phone Number ()	Home Phone Number ()	E-Mail Address			

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

MEDICAL PLAN:	<input type="checkbox"/> No Medical Coverage <input type="checkbox"/> Blue Options HSA SM <input type="checkbox"/> Blue Options PPO <input type="checkbox"/> Blue Options 1-2-3 <input type="checkbox"/> Blue Care® (HMO) <input type="checkbox"/> Classic Blue® (CMM)	<input type="checkbox"/> High <input type="checkbox"/> Low
MEDICAL COVERAGE (if applicable):	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family	
DENTAL PLAN:	<input type="checkbox"/> No Dental Coverage <input type="checkbox"/> Dental Blue	
DENTAL COVERAGE (if applicable):	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family	

An independent licensee of the Blue Cross and Blue Shield Association. ®,SM Marks of the Blue Cross and Blue Shield Association. SM1 Mark of Blue Cross and Blue Shield of North Carolina.

Your plan for better health. | bcbnsnc.com



BlueCross BlueShield of North Carolina

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

NAME First, Middle Initial, Last, Suffix	Social Security Number	Marital Status	Birthdate	Sex	H E I G H T	W E I G H T	H E A L T H	D E N T A L	Child Status* (if applicable)
Employee		<input type="checkbox"/> Single <input type="checkbox"/> Married	mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse			mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Child 1			mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**
Child 2			mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**
Child 3***			mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**

* Consult your employer regarding dependent eligibility requirements.
 ** A Coverage Request for Mentally Retarded or Physically Handicapped Children (P24) form is required.
 *** If you have more than three children, complete **Section D** on another application.

E. OTHER HEALTH/DENTAL INSURANCE INFORMATION

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 <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>
Effective Date <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>	Termination Date or Expected Termination Date <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>		(If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)			
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents			
Additional Coverage:			
Insurance Carrier		Policy Number	
Policy Holder Name			Date of Birth <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>
Effective Date <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>	Termination Date or Expected Termination Date <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>		(If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)			
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents			
Additional Coverage:			
Insurance Carrier		Policy Number	
Policy Holder Name			Date of Birth <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>
Effective Date <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>	Termination Date or Expected Termination Date <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YYYY"/>		(If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)			
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> 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 Disability Age

Part A Effective Date: Part B Effective Date:

F. LEGAL NOTICES

Notice About Your Pre-Existing Condition Limitations

This plan imposes a pre-existing condition exclusion for all employees and dependents whether they are timely or late enrollees. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days of birth, adoption, or placement for adoption or foster care. Eligible children (newborns, adoptive children, foster children, and those added as a result of a court order) are not subject to this exclusion period when enrolled more than 30 days after one of the events listed above if your coverage type or the premiums owed are not affected by adding the child. When applicable, this exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage".

Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give Blue Cross and Blue Shield of North Carolina (BCBSNC) a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, BCBSNC will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact BCBSNC if you need help demonstrating creditable coverage. Throughout this notice, all references to "you" are meant to refer to both the employee and their dependents.

Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your 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" or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption or foster care.

For questions or to obtain more information, contact a BCBSNC Customer Service Representative at:

**Blue Cross and Blue Shield of North Carolina Customer Service
1-877-258-3334**

G. HEALTH QUESTIONS

All questions in this Section (Section G) MUST be answered in their entirety. Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information. Please use "Month/Day/Year" where required.

PLEASE NOTE: "Section G2" information is required for all disorders with a "YES" answer.

Has any person applying for coverage sought medical attention and/or advice, been diagnosed with or been treated for any of the following diseases or disorders (this includes diseases or disorders past and present):

DISORDER	YES	NO	DISORDER	YES	NO
1. Heart attack, angina, angioplasty, stent placement, bypass surgery, coronary artery disease or congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	9. Chronic fatigue, chronic fibromyalgia, Epstein Barr and/or chronic lyme disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. An irregular heart rhythm that requires treatment?	<input type="checkbox"/>	<input type="checkbox"/>	10. a. Depression?	<input type="checkbox"/>	<input type="checkbox"/>
3. Hypertension or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	b. Anxiety/stress?	<input type="checkbox"/>	<input type="checkbox"/>
a. How many times a year do you contact or visit your doctor to get a prescription for your hypertension, either to renew your current prescription or get a different or additional prescription to treat your hypertension? _____			c. Chemical imbalance?	<input type="checkbox"/>	<input type="checkbox"/>
4. Emphysema, chronic bronchitis or chronic obstructive pulmonary disorder (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>	d. Obsessive compulsive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
a. Any use of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	e. Bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. Any inpatient treatment at a hospital for any of the above conditions?	<input type="checkbox"/>	<input type="checkbox"/>	f. Suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>
5. Elevated cholesterol treated with medication within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	11. Brain damage, paralysis, stroke, Transient Ischemic Attack (TIA) or Hydrocephalus?	<input type="checkbox"/>	<input type="checkbox"/>
6. Inpatient or outpatient treatment at a hospital for asthma within the past 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	12. Kidney stones or renal colic within the past 36 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. a. Hepatitis A?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you have gall bladder disease or gall stones and STILL have your gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>
b. Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>	14. Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>
c. Hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>	15. a. Colitis?	<input type="checkbox"/>	<input type="checkbox"/>
d. Hepatitis D?	<input type="checkbox"/>	<input type="checkbox"/>	b. Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>
8. Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, Parkinson's disease, Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>	c. Irritable bowel syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
			d. Inflammatory bowel disease?	<input type="checkbox"/>	<input type="checkbox"/>
			e. Familial polyposis?	<input type="checkbox"/>	<input type="checkbox"/>
			16. Osteoarthritis in the hips or knees?	<input type="checkbox"/>	<input type="checkbox"/>