

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.

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

Completed by Group Administrator Only			
Effective Date	MM	DD	YYYY
Group Number			
Life Class Designation (if applicable):			

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

<p>Check All That Apply:</p> <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 _____	<p>Add Dependent(s):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><input type="checkbox"/> Marriage</td> <td style="width: 20%; text-align: center;">Date of Occurrence</td> <td style="width: 10%; text-align: center;">MM</td> <td style="width: 10%; text-align: center;">DD</td> <td style="width: 40%; text-align: center;">YYYY</td> </tr> <tr> <td><input type="checkbox"/> Newborn</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> <tr> <td><input type="checkbox"/> Adoption</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> </table> <p>Remove Dependent(s):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><input type="checkbox"/> Marriage</td> <td style="width: 20%; text-align: center;">Date of Occurrence</td> <td style="width: 10%; text-align: center;">MM</td> <td style="width: 10%; text-align: center;">DD</td> <td style="width: 40%; text-align: center;">YYYY</td> </tr> <tr> <td><input type="checkbox"/> Divorce</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> <tr> <td><input type="checkbox"/> Dependent Age</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> <tr> <td><input type="checkbox"/> Death</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> </table>	<input type="checkbox"/> Marriage	Date of Occurrence	MM	DD	YYYY	<input type="checkbox"/> Newborn		MM	DD	YYYY	<input type="checkbox"/> Adoption		MM	DD	YYYY	<input type="checkbox"/> Other _____		MM	DD	YYYY	<input type="checkbox"/> Marriage	Date of Occurrence	MM	DD	YYYY	<input type="checkbox"/> Divorce		MM	DD	YYYY	<input type="checkbox"/> Dependent Age		MM	DD	YYYY	<input type="checkbox"/> Death		MM	DD	YYYY	<input type="checkbox"/> Other _____		MM	DD	YYYY	<p>Reinstate Coverage:</p> <p>Reason: _____</p> <hr/> <p>Cancel Coverage:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><input type="checkbox"/> Not Eligible</td> <td style="width: 20%; text-align: center;">Date of Occurrence</td> <td style="width: 10%; text-align: center;">MM</td> <td style="width: 10%; text-align: center;">DD</td> <td style="width: 40%; text-align: center;">YYYY</td> </tr> <tr> <td><input type="checkbox"/> Left Employment</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> <tr> <td><input type="checkbox"/> Subscriber Request</td> <td></td> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Reason: _____</p> <hr/>	<input type="checkbox"/> Not Eligible	Date of Occurrence	MM	DD	YYYY	<input type="checkbox"/> Left Employment		MM	DD	YYYY	<input type="checkbox"/> Subscriber Request		MM	DD	YYYY	<input type="checkbox"/> Other				
<input type="checkbox"/> Marriage	Date of Occurrence	MM	DD	YYYY																																																															
<input type="checkbox"/> Newborn		MM	DD	YYYY																																																															
<input type="checkbox"/> Adoption		MM	DD	YYYY																																																															
<input type="checkbox"/> Other _____		MM	DD	YYYY																																																															
<input type="checkbox"/> Marriage	Date of Occurrence	MM	DD	YYYY																																																															
<input type="checkbox"/> Divorce		MM	DD	YYYY																																																															
<input type="checkbox"/> Dependent Age		MM	DD	YYYY																																																															
<input type="checkbox"/> Death		MM	DD	YYYY																																																															
<input type="checkbox"/> Other _____		MM	DD	YYYY																																																															
<input type="checkbox"/> Not Eligible	Date of Occurrence	MM	DD	YYYY																																																															
<input type="checkbox"/> Left Employment		MM	DD	YYYY																																																															
<input type="checkbox"/> Subscriber Request		MM	DD	YYYY																																																															
<input type="checkbox"/> Other																																																																			

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?	MM	DD	YYYY
Date Continuation Started	MM	DD	YYYY
Date Continuation Ends	MM	DD	YYYY
First Name	Middle Initial	Last Name	
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	MM	DD
		YYYY	Language Preference
			<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"/> High
	<input type="checkbox"/> Blue Care [®] (HMO)	<input type="checkbox"/> Classic Blue [®] (CMM)	<input type="checkbox"/> Blue Options HRA SM	<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. | bcbsnc.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** <input type="checkbox"/> Full-Time Student
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** <input type="checkbox"/> Full-Time Student
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** <input type="checkbox"/> Full-Time Student

* 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

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: <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		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: <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		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: <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										

Employee Name:

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: [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.

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 Percent¹

Second Primary Beneficiary Name (required) Second Primary Beneficiary Address (required)

Relationship Date of Birth [MM][DD][YYYY] Social Security Number Percent¹

Contingent Beneficiary Name (required) Contingent Beneficiary Address (required)

Relationship Date of Birth [MM][DD][YYYY] Social Security Number Percent¹

Second Contingent Beneficiary Name (required) Second Contingent Beneficiary Address (required)

Relationship Date of Birth [MM][DD][YYYY] Social Security Number Percent¹

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:

3. Have you used any tobacco products in the past year? Yes No

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?

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

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

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

Signature of Spouse: **X** _____ Date

Signature of Adult Dependent(s): **X** _____ Date