

Enrollment/Change Application

Instructions:

- All employees complete Sections A, 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 you must complete Sections A, B, F, G and H.
- If declining coverage, please complete Sections A and C.

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

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

A. Employee information

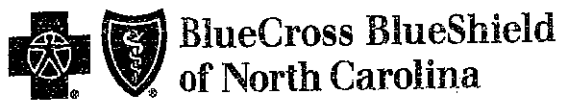
First Name		Middle Initial	Last Name		Suffix						
Employee Birthdate	mm	dd	yyyy	Employee Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status					
Address		P.O. Box	Apt. No.	City	State	Zip Code					
		(For Blue Options HSA you must also provide a street address.)									
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						
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"/> 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) _____											
<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

B. 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: mm dd yyyy <input type="checkbox"/> Newborn Date of Occurrence: mm dd yyyy <input type="checkbox"/> Adoption Date of Occurrence: mm dd yyyy <input type="checkbox"/> Other _____ Date of Occurrence: mm dd yyyy	Reinstate Coverage: Reason: _____ _____	
	Remove Dependent(s): <input type="checkbox"/> Divorce Date of Occurrence: mm dd yyyy <input type="checkbox"/> Dependent Age Date of Occurrence: mm dd yyyy <input type="checkbox"/> Death Date of Occurrence: mm dd yyyy <input type="checkbox"/> Other _____ Date of Occurrence: mm dd yyyy	Cancel Coverage: <input type="checkbox"/> Not Eligible Date of Occurrence: mm dd yyyy Reason: _____ <input type="checkbox"/> Left Employment Date of Occurrence: mm dd yyyy <input type="checkbox"/> Subscriber Request Date of Occurrence: mm dd yyyy <input type="checkbox"/> Other Reason: _____	

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Employee Name: _____

C. Benefits and coverage selection - complete for BCBSNC health and dental, if offered by employer

MEDICAL PLAN: No Medical Coverage Blue Options HSASM Blue OptionsSM (PPO) Blue Options 1-2-3SM Blue SelectSM (PPO) High Paired with HRA
 Blue Care[®] (HMO) Classic Blue[®] (CMM) Blue ValueSM (POS) Low

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

DENTAL PLAN: No Dental Coverage Dental High Low

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

DECLINE 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
 - An individual plan
 - My spouse's group coverage
 - COBRA or State Continuation
 - I and/or my dependents are not covered by any other health benefit plan
 - A government plan (type): _____
 - Other (explain): _____

Names of any dependents rejecting coverage: _____

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this employer health benefit plan at a later time, the application may be subject to an extended waiting period for preexisting conditions or 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.

Date: _____ Employee Signature if waiving coverage: _____

Notice of Declination of Coverage must be received by Blue Cross and Blue Shield of North Carolina within 30 days of the date that employee is first eligible for coverage.

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	H E A L T H	D E N T A L	Child Status (please check one)
Spouse	required		<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			<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"/> Under the age of 26***
Child 2			<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"/> Under the age of 26***
Child 3****			<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"/> 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.

Additional dependent and/or custodial parent information attached.

Employee Name:

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, Effective Date, Termination Date or Expected Termination Date, What kind of coverage, Persons covered

Additional Coverage that will be in-force when this policy becomes active: Insurance Carrier, Policy Number, Policy Holder Name, Date of Birth, Effective Date, Termination Date or Expected Termination Date, What kind of coverage, Persons covered

Additional Coverage that will be in-force when this policy becomes active: Insurance Carrier, Policy Number, Policy Holder Name, Date of Birth, Effective Date, Termination Date or Expected Termination Date, What kind of coverage, Persons covered

Additional Coverage that will be in-force when this policy becomes active: Insurance Carrier, Policy Number, Policy Holder Name, Date of Birth, Effective Date, Termination Date or Expected Termination Date, What kind of coverage, Persons covered, Medicare Claim Number, Eligible Due To, Part A Effective Date, Part B Effective Date

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, Dependent Life, Weekly Disability, Long Term Disability, Supplemental Life/AD&D, Supplemental Life/AD&D Amount, No Benefits Selected, Applying For Over Guarantee Issue

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, Social Security Number, Percent'

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

Relationship, Date of Birth, Social Security Number, Percent'

Employee Name:

Contingent Beneficiary Name (required)		Contingent Beneficiary Address (required)	
Relationship	Date of Birth	Social Security Number	Percent ¹
mm	dd	yyy	

Second Contingent Beneficiary Name (required)		Second Contingent Beneficiary Address (required)	
Relationship	Date of Birth	Social Security Number	Percent ¹
mm	dd	yyy	

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 yyy

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:
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	Yes	No
3. Have you used any tobacco products in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any condition for which consultation or treatment is contemplated or has been advised?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been hospitalized for any reason during the past five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you consulted a physician in the past one (1) year for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Disease of the heart or blood vessels, or had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
c. Kidney disease or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
d. Alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
e. Lung, asthma, liver or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Emotional, nervous system, eating disorder, or mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>
g. Ulcer, stomach or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h. Arthritis, back, bones or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i. Bladder, urinary system or reproductive organs disorder?	<input type="checkbox"/>	<input type="checkbox"/>
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")?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you currently taking medication(s)? If yes, list name of person, medications and dosage.	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had any impairments, diseases or illnesses not covered in questions 2-8?	<input type="checkbox"/>	<input type="checkbox"/>
12a. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
12b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?	<input type="checkbox"/>	<input type="checkbox"/>

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:

Employee Name:

G. Statement of understanding – your signature is required

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina (BCBSNC) and/or the life insurance carrier (USABLE Life) contract (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 BCBSNC and/or the life insurance carrier 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, BCBSNC may take legal action at any time.

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 a medical plan paired with an 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	yy
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