BlueCross BlueShield of North Carolina

COMPLETED BY GROUP ADMINISTRATOR ONLY

Effective Date _____

Group Number _____

Package Number _____

Dept/Division/Class _____

ENROLLMENT AND CHANGE APPLICATION

- ***Instructions: ALL new Employees Complete B, C, D, E, G***
- **PLEASE TYPE OR PRINT IN INK.**
- ☐ **Change Request: (Please complete sections A, B and any other applicable selections.**

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

CHECK ALL THAT APPLY:	ADD DEPENDENT(S):	REMOVE DEPENDENT(S):	CHECK ALL THAT APPLY:	CANCEL COVERAGE
Name Change Address Change Telephone Change Replace ID Card Date of Birth Correction Open Enrollment Other Insurance Information	Marriage Newborn Adoption Other Date of occurrence: _____	Marriage Divorce Student Status Death Other Date of occurrence: _____	Elect Continuation Effective: _____ Termination of Employment	Effective_____

B. EMPLOYEE INFORMATION

Active Employee	**Percentage of Appointment**: ☐ ½ ☐ ¾ ☐ Full Time	**District**:

FIRST NAME/MIDDLE INITIAL	LAST NAME	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTHDATE

ADDRESS	CITY	COUNTY	STATE AND ZIP

E-MAIL ADDRESS (optional)	☐ FEMALE ☐ MALE	HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )	OCCUPATION

MARITAL STATUS	CHURCH NAME	CHURCH LOCATION	DATE OF FULL TIME EMPLOYMENT
☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED			

C. COVERAGE SELECTION Complete for BCBSNC Health and Dental

COVERAGE:	Blue Options (PPO)		Dental (Optional)
	____ Medical BASE PLAN		____Medical BUY-UP PLAN
Medical Benefits Selected:	____Employee Only	____Employee and Child	____Employee and Family
Dental Benefits Selected:	____Employee Only	____Employee and Child	____Employee and Family

D. FAMILY INFORMATION Complete for anyone taking Medical and Dental Coverage

• List family members taking medical or dental. If any dependent children are covered all children must be covered. • Student status and handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents.

NAME (First, Middle Initial, Last)	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	HEALTH	DENTAL	IF CHILD IS OVER AGE 19, PLEASE INDICATE STATUS AND SCHOOL NAME	CHILD STATUS (if applicable)
SPOUSE			☐FEMALE ☐MALE	☐YES ☐NO	☐YES ☐NO		
CHILD 1			☐FEMALE ☐MALE	☐YES ☐NO	☐YES ☐NO	Full-time Student at: Handicapped	Foster1 Adopted1
CHILD 2			☐FEMALE ☐MALE	☐YES ☐NO	☐YES ☐NO	Full-time Student at: Handicapped	Foster1 Adopted1
CHILD 3			☐FEMALE ☐MALE	☐YES ☐NO	☐YES ☐NO	Full-time Student at: Handicapped	Foster1 Adopted1
CHILD 4			☐FEMALE ☐MALE	☐YES ☐NO	☐YES ☐NO	Full-time Student at: Handicapped	Foster1 Adopted1

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Please attach additional documentation required (see instructions). If you have more than three children, please complete **Section D** on another application. ENROLL2, 3/03 An Independent Licensee of the Blue Cross and Blue Shield Association

Application is continued on reverse side

Employee Name _____

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION

Have you had any health insurance within the last sixty-three (63) days?

E1. **PRIOR HEALTH INSURANCE** This section **MUST** be completed to receive credit for prior coverage and **REDUCE** or **ELIMINATE** any applicable waiting period. **BCBSNC will assist in obtaining a certificate of coverage from any prior plan or issuer, if necessary.** Yes No **IF YES, complete below:**

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY		POLICY NUMBER	
POLICYHOLDER NAME AND DATE OF BIRTH	EFFECTIVE DATE	TERMINATION DATE OR EXPECTED TERMINATION DATE	**If other coverage will remain in effect, write N/A in term box, and complete section below.** ➡
FAMILY MEMBERS COVERED **LIST NAMES AND RELATIONSHIPS**:			
Have you or any family dependents been a previous Blue Cross and Blue Shield of North Carolina member?..... Yes No		DATES AND ID NUMBER	

Will you or your covered dependents have other insurance in addition to this policy?

E2. **OTHER HEALTH INSURANCE** This section **MUST** be completed if you will have additional insurance in force during this new policy. Yes No Are any dependents covered under another plan due to divorce/separation? Yes No **IF YES TO EITHER QUESTION, complete E2 below**

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY		POLICYHOLDER NAME AND DATE OF BIRTH	
POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE		If Individual coverage check here	POLICY HOLDER'S SOCIAL SECURITY NUMBER
POLICY NUMBER		EFFECTIVE DATES OF COVERAGE From: To:	
INDIVIDUALS COVERED		FAMILY MEMBERS COVERED BY MEDICARE	
MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO: RENAL DISEASE AGE DISABILITY	**PART A** EFFECTIVE DATE	**PART B** EFFECTIVE DATE

F. COVERAGE SELECTION

NOT APPLICABLE

G. STATEMENT OF UNDERSTANDING AND AUTHORIZATION

I understand that the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina and/or the life insurance carrier contract and any changes provided for therein. **I understand that BCBSNC and/or the life insurance carrier may, within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, BCBSNC may take legal action at any time. 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 Employee Signature:_____ Date _____