ENROLLMENT AND CHANGE APPLICATION *with health questions*

☐ **Change Request:** *For changes, complete sections **A**, **B**, and all other applicable sections*

Instructions: ALL new Employees Complete **B**, **C**, **D**, **E**, **F**, **H**
If your group has selected any Life Products also complete and provide your signature in **G**
ALL dates should be indicated as (mm/dd/yyyy)

☐ **PLEASE CHECK THIS BOX IF YOU WOULD LIKE SPANISH MATERIALS (WHEN AVAILABLE)**

PLEASE TYPE OR PRINT IN BLACK OR BLUE INK. PRESS FIRMLY.

COMPLETED BY GROUP ADMINISTRATOR ONLY

Effective Date _____ *(mm/dd/yyyy)*

Group Number _____

Package Number _____

Dept/Division/Class _____

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

CHECK ALL THAT APPLY:
- ☐ Name Change
- ☐ Address Change
- ☐ Telephone Change
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ Open Enrollment
- ☐ Other Insurance Information

ADD DEPENDENT(S): / DATE *(mm/dd/yyyy)* OF OCCURRENCE:
- ☐ Marriage _____
- ☐ Newborn _____
- ☐ Adoption _____
- ☐ Other _____
- _____ _____
- _____ _____
- _____ _____

REMOVE DEPENDENT(S): / DATE *(mm/dd/yyyy)* OF OCCURRENCE:
- ☐ Marriage _____
- ☐ Divorce _____
- ☐ Student Status _____
- ☐ Death _____
- ☐ Other _____
- _____ _____
- _____ _____

CHECK ALL THAT APPLY:
- ☐ ELECT COBRA EFFECTIVE: _____

COBRA QUALIFYING EVENT:
- ☐ Termination of Employment
- ☐ Reduction in Hours
- ☐ Divorce
- ☐ Medicare Eligible
- ☐ Social Security Disability Determination
- ☐ Overaged Dependent Now Ineligible
- ☐ Death

☐ CANCEL COVERAGE

REINSTATE COVERAGE:
- ☐ Return from Layoff
- ☐ Return from Leave
- ☐ Retirement
- ☐ Disenrollment Error
- ☐ Other
- _____
- _____
- _____

B. EMPLOYEE INFORMATION

☐ Active Employee ☐ COBRA/State Continuation: | DATE CONTINUATION STARTED (mm/dd/yyyy) ___/___/___ | DATE CONTINUATION ENDS (mm/dd/yyyy) ___/___/___

FIRST NAME/MIDDLE INITIAL	LAST NAME	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTHDATE (mm/dd/yyyy)
			___/___/___

ADDRESS	APT. NO.	CITY	COUNTY	STATE AND ZIP

YOUR E-MAIL ADDRESS *(optional)*	☐ MALE ☐ FEMALE	HEIGHT	WEIGHT	HOME PHONE NUMBER	WORK PHONE NUMBER	OCCUPATION
				( )	( )	

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED | COMPANY NAME | WORK LOCATION | DATE OF FULL TIME EMPLOYMENT (mm/dd/yyyy) ___/___/___

C. COVERAGE SELECTION - Complete for BCBSNC Health and Dental

COVERAGE: *(Check only one medical plan)* ☐ Blue Care® (HMO) ☐ Blue Options℠ (PPO) ☐ Blue Options HSA℠ ☐ Classic Blue® (CMM) ☐ Dental Blue

☐ **Medical Benefits Selected:** ☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Employee and Family ☐ No Medical Benefits

☐ **Dental Benefits Selected:** ☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Employee and Family ☐ No Dental Benefits

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

- List family members taking medical or dental.
- 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**	**HEIGHT**	**WEIGHT**	**HEALTH**	**DENTAL**	**IF CHILD IS OVER AGE 19, PLEASE INDICATE STATUS AND SCHOOL NAME**	**CHILD STATUS** *(if applicable)*
SPOUSE			☐ MALE ☐ FEMALE			☐ YES ☐ NO	☐ YES ☐ NO		
CHILD 1			☐ MALE ☐ FEMALE			☐ YES ☐ NO	☐ YES ☐ NO	☐ Handicapped ☐ Full-time Student at: _____	☐ Foster ☐ Adopted
CHILD 2			☐ MALE ☐ FEMALE			☐ YES ☐ NO	☐ YES ☐ NO	☐ Handicapped ☐ Full-time Student at: _____	☐ Foster ☐ Adopted
CHILD 3*			☐ MALE ☐ FEMALE			☐ YES ☐ NO	☐ YES ☐ NO	☐ Handicapped ☐ Full-time Student at: _____	☐ Foster ☐ Adopted

*If you have more than three children, please complete **Section D** on another application.

Application is continued on reverse side ➔

Employee Name _____

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION

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.

Have you had any health insurance within the last sixty-three (63) days? ☐ Yes ☐ No ***IF YES, complete below:***

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY

POLICY NUMBER	POLICYHOLDER NAME	POLICYHOLDER DATE OF BIRTH (mm/dd/yyyy)
		___/___/___

EFFECTIVE DATE (mm/dd/yyyy)	TERMINATION DATE OR EXPECTED TERMINATION DATE (mm/dd/yyyy)	← *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 NUMBERS

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 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

E2. OTHER HEALTH INSURANCE

*This section **MUST** be completed if you will have additional insurance in force during this new policy.*

Will you or your covered dependents have other insurance in addition to this 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 (mm/dd/yyyy)
	___/___/___

POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE	If Individual coverage check here ☐	POLICY NUMBER

POLICY HOLDER'S SOCIAL SECURITY NUMBER	EFFECTIVE DATES OF COVERAGE (mm/dd/yyyy)
	From: ___/___/___ To: ___/___/___

INDIVIDUALS COVERED	FAMILY MEMBERS COVERED BY MEDICARE

MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO:	**PART A** EFFECTIVE DATE (mm/dd/yyyy)	**PART B** EFFECTIVE DATE (mm/dd/yyyy)
	☐ RENAL DISEASE ☐ AGE ☐ DISABILITY	___/___/___	___/___/___

Application is continued on next page →

Employee Name _____

F. HEALTH QUESTIONS

All questions in this Section *(Section F)* 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 F.2" 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
1. Heart attack, angina, angioplasty, stent placement, bypass surgery, coronary artery disease or congestive heart failure?	☐	☐
2. An irregular heart rhythm that requires treatment?	☐	☐
3. Hypertension or high blood pressure?	☐	☐
a. How many times has a doctor been seen for hypertension or high blood pressure in the last 12 months? _____		
4. Emphysema, chronic bronchitis or chronic obstructive pulmonary disorder (COPD)?	☐	☐
a. Any use of oxygen?	☐	☐
b. Any inpatient treatment at a hospital for any of the above conditions?	☐	☐
5. Elevated cholesterol treated with medication within the last 12 months?	☐	☐
6. Inpatient or outpatient treatment at a hospital for asthma within the past 24 months?	☐	☐
7. a. Hepatitis A?	☐	☐
b. Hepatitis B?	☐	☐
c. Hepatitis C?	☐	☐
d. Hepatitis D?	☐	☐
8. Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, Parkinson's disease, Alzheimer's disease?	☐	☐
9. Chronic fatigue, chronic fibromyalgia, Epstein Barr and/or chronic lyme disease?	☐	☐
10. a. Depression?	☐	☐
b. Anxiety/stress?	☐	☐
c. Chemical imbalance?	☐	☐
d. Obsessive compulsive disorder?	☐	☐
e. Bipolar disorder?	☐	☐
f. Suicidal thoughts?	☐	☐
11. Brain damage, paralysis, stroke, Transient Ischemic Attack (TIA) or Hydrocephalus?	☐	☐
12. Kidney stones or renal colic within the past 36 months?	☐	☐
13. Gall bladder disease including gall stones but has NOT had gall bladder removed?	☐	☐
14. Cirrhosis of the liver?	☐	☐
15. a. Colitis?	☐	☐
b. Crohn's disease?	☐	☐
c. Irritable bowel syndrome?	☐	☐
d. Inflammatory bowel disease?	☐	☐
e. Familial polyposis?	☐	☐
16. Osteoarthritis in the hips or knees?	☐	☐
17. Joint replacement, or recommended joint replacement?	☐	☐
a. Primary - Date of surgery: MM / DD / YY		
b. Spouse - Date of surgery: MM / DD / YY		
18. Arthritis, such as inflammatory arthritis, rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis?	☐	☐
19. Diabetes?	☐	☐
a. Primary - Date of diagnosis: MM / DD / YY		
b. Spouse - Date of diagnosis: MM / DD / YY		
c. What is the most recent hemoglobin A1C level?		
Primary: _____ Spouse: _____		

DISORDER	YES	NO
20. Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
21. Within the last five years has anyone been diagnosed or had surgery, radiation therapy or chemotherapy for:		
a. Cancer/malignancy, including melanoma?	☐	☐
b. Other forms of skin cancer?	☐	☐
22. Prostate disorders, including enlarged prostate, benign prostatic hypertrophy or elevated readings?	☐	☐
23. Bleeding disorder, such as Hemophilia or Von Willebrand's?	☐	☐
24. Sickle cell anemia, aplastic anemia or thalassemia major?	☐	☐
25. Moderate or severe psoriasis?	☐	☐
26. Sleep apnea?	☐	☐
27. Epilepsy or seizure disorder?	☐	☐
a. If yes, was the most recent seizure within the last 3 months?	☐	☐
28. Has anyone who is less than 12 years of age had more than 3 ear infections in the last year?	☐	☐
29. Has anyone ever had the following procedures or treatments performed:		
a. Spinal fusion?	☐	☐
b. Gastric bypass or gastric restrictive procedures, such as lap band?	☐	☐
c. Heart valve replacement?	☐	☐
d. Anterior cruciate ligament (ACL) repair and still in therapy?	☐	☐
e. Cerebral shunt placement?	☐	☐
f. Permanent colostomy/ileostomy?	☐	☐
g. Surgery related to gastro esophageal reflux disorder (GERD)?	☐	☐
h. Any internal organ transplant?	☐	☐
i. Kidney dialysis?	☐	☐
j. Any past surgical procedure resulting in complications that still require treatment?	☐	☐
30. Has anyone been advised or scheduled to have surgery within the next 6 months?	☐	☐
31. Within the last 12 months, has anyone seen an allergist or received an immuno-therapy injection?	☐	☐
32. Has anyone been treated within the last 2 years for an eating disorder?	☐	☐
33. Has anyone seen a chiropractor or physical therapist more than 5 times in the last 12 months?	☐	☐
a. Primary - Date of your last visit: MM / DD / YY		
b. Spouse - Date of your last visit: MM / DD / YY		
34. Has anyone had any treatment in the last year for disc disorder of back or neck including surgery or injection therapy other than chiropractic care or physical therapy?	☐	☐
35. More than 2 breast biopsies in the last 5 years?	☐	☐
36. Within the past 12 months, has anyone had any treatment for heavy, frequent, AND prolonged periods; uterine fibroids; or endometriosis; but have NOT had total abdominal hysterectomy (TAH)?	☐	☐
37. Have either of your last two pap smears been abnormal?	☐	☐
38. Does anyone exercise for at least 20 minutes per day 3 or more times per week?	☐	☐

DISORDER	YES	NO
39. Within the last 12 months, has anyone smoked cigarettes, marijuana, cigars, pipes or used chewing tobacco or snuff?	☐	☐
40. Has anyone applying for coverage on this application taken or used any of the following categories of prescription medications within the last 12 months:		
a. Anti-depressant?	☐	☐
b. Anti-psychotic?	☐	☐
c. Anti-anxiety?	☐	☐
d. Attention deficit (ADD) or attention deficit hyperactivity (ADHD) medication?	☐	☐
e. Antabuse?	☐	☐
f. Migraine medication?	☐	☐
g. Tracleer?	☐	☐
h. Blood thinner/anti-coagulant medication?	☐	☐
i. Nitroglycerin, Digoxin or Lanoxin?	☐	☐
j. Immunosuppressive medication, such as, Methotrexate, Imuran, Cytoxan?	☐	☐
k. Daily oral steroid or steroid injections?	☐	☐
l. Plaquenil/Hydroxycholoroquine?	☐	☐
m. Growth hormones such as: Humotrope, Genotropin, Nutropin, Norditropin?	☐	☐
n. Gastrointestinal medication, such as Nexium?	☐	☐
o. Arava?	☐	☐
p. Remicade?	☐	☐
q. Enbrel?	☐	☐
r. Infertility medication?	☐	☐
s. Pancreatic enzymes used in the treatment of Cystic Fibrosis, such as, Creon, Pancrease, Ultrase, Lipram?	☐	☐
t. Synagis?	☐	☐

We need to know only about medications that are specified in Question 40.
Please do not list any other medications.

41. Does anyone have a physical or mental impairment that substantially limits one or more major life activities: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working? ☐ ☐
Describe each such physical or mental impairment and identify the person with such physical or mental impairment:

_____

Please describe how the physical or mental impairment substantially limits one or more of the major life activities stated previously:

_____

If yes, is the physical or mental impairment temporary or correctable? ☐ ☐
If yes, please explain how the physical or mental impairments are temporary or how the person plans to have it corrected:

_____

42. Is anyone aware of any symptoms or conditions that have not yet been diagnosed by a doctor? ☐ ☐
If yes, list them below:

_____

43. Does anyone have any other conditions or symptoms for which no question was provided? ☐ ☐
If yes, list them below:

_____

F.2 For each item checked "YES" in the Section above, please provide condition or diagnosis for each person.

	Person #1 Name:	Person #2 Name:	Person #3 Name:
Condition or Diagnosis:			

If additional space is needed, please attach a separate sheet, with your signature and the date (mm/dd/yyyy).

Application is continued on reverse side →

Employee Name _____

G. COVERAGE SELECTION

Underwritten by: ☐ **Fort Dearborn Life Insurance Company** ☐ **USAble Life for Life, AD&D, Disability** ***(if offered by employer)***

Coverage Selection:

Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

Life / AD&D ..... ☐ **Yes** ☐ **No**

Dependent Life ..... ☐ **Yes** ☐ **No**

Weekly Disability ..... ☐ **Yes** ☐ **No**

Long Term Disability ..... ☐ **Yes** ☐ **No**

Supplemental Life / AD&D ..... ☐ **Yes** ☐ **No** **Amount:** _____

☐ **NO BENEFITS SELECTED**

EMPLOYEE SALARY: _____ ☐ WEEKLY ☐ MONTHLY ☐ ANNUAL

PRIMARY BENEFICIARY NAME AND ADDRESS ***(REQUIRED)***

RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	PERCENT[1]
	____/____/____		

CONTINGENT BENEFICIARY NAME AND ADDRESS ***(REQUIRED)***

RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	PERCENT[1]
	____/____/____		

[1] Note: the primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I selected Life that I will be covered by Fort Dearborn Life Insurance Company or 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 *(coverage listed in Section G of this application)* 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)

H. 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.

BLUE OPTIONS HSA PLANS ONLY:

I understand that if I am applying for Blue Options HSA, BCBSNC takes no responsibility for determining eligibility to contribute to an HSA. Please check with your tax advisor for questions. The HSA fund is provided to you directly by a separate Administrator that is unaffiliated with BCBSNC. The HSA is not part of the health benefit plan administered by BCBSNC. BCBSNC is not responsible or liable for administration of the fund. Detailed information regarding your HSA will be provided by that Administrator. I also understand that due to bank regulations, I will be unable to open or deposit money into an HSA if I provide a P.O. Box as my address

If your employer selects a BCBSNC fund administrator, BCBSNC will share certain personal information about you with such administrator to facilitate the administrator's establishment of your fund. By signing this application, you are authorizing BCBSNC to share pertinent information with the administrator, which may include your name, address, social security number and employer name.

The "Blue Options HSA" product is a High-Deductible Health Plan that qualifies its members to contribute to a Health Savings Account (HSA), unless its members are otherwise ineligible under applicable federal requirements. If unsure about whether ineligible, members should consult a qualified tax advisor.

By signing this application, you are authorizing the fund administrator to establish an HSA fund on your behalf, as of the date corresponding with the effective date of your High Deductible Health Plan with BCBSNC. In order to activate the fund, you will need to provide additional authorization through documents that will be provided to you by the fund administrator.

If you are issued a debit card in connection with your fund, you agree that although BCBSNC's name and marks may be included on the face of the debit card for your convenience, BCBSNC is not responsible or liable for administration of your debit card. The terms and conditions associated with your debit card are governed by your agreement with the bank issuing the card.

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 ____/____/____ (mm/dd/yyyy)