



CHECK BOX:

- ENROLLMENT FORM - New Members: Complete all items in Sections B, C, D, E, F, G.
CHANGE FORM - Current Members: Check all items you wish to change under Section A. Complete Section B. Update other appropriate sections with changes.

ENROLLMENT APPLICATION AND CHANGE FORM

(NOTE: Do not fill in shaded areas. PLEASE USE INK.)

TO BE COMPLETED BY GROUP ADMINISTRATOR ONLY

Group No.:
Dept./Div. No.:
Effective Date:
Admin. Name:

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT:

CHECK ALL THAT APPLY: Name Change, Address Change, Telephone Change, Primary Care Physician Change, Date of Birth Correction, ID Card Request, Open Enrollment.
ADD DEPENDENT(S): Marriage, Newborn, Adoption, Other.
CANCEL DEPENDENT(S): Marriage, Divorce, Separation, Age Limit, Death, Other.
COBRA: Elect COBRA, Effective Date, COBRA QUALIFYING EVENT: Death, Termination of Employment, Reduction in Hours, Divorce, Separation, Medicare Eligibility, Social Security Disability Determination, Overaged Dependent Now Ineligible.
REINSTATEMENT: Return from Layoff, Return from Leave, Retire, Disenrollment Error, Other.

B. EMPLOYEE INFORMATION:

SOCIAL SECURITY NUMBER, LAST NAME, FIRST NAME, MIDDLE INITIAL, MARITAL STATUS, SEX, DATE OF BIRTH, ADDRESS, CITY, STATE, ZIP, HOME PHONE, DATE OF FULL-TIME EMPLOYMENT, EMPLOYER NAME, ADDRESS, OCCUPATION, WORK PHONE.

C. COVERAGE ELECTION: Please complete the Rejection of Coverage Form (C246) for you and/or any eligible family members not to be covered on this policy.

CHECK ONE: Personal Care Plan (PCP), MedPoint, Preferred Care, Comp. Major Medical, Other.
CHECK ONE: Employee Only, Employee/Spouse, Employee/Child, Employee/Children, Family, Other.
PACKAGE NUMBER

D. FAMILY INFORMATION:

Table with columns: NAME (First, Middle Initial, Last), SOCIAL SECURITY NUMBER, BIRTH DATE, SEX, PRIMARY CARE PHYSICIAN (Full Name), PROVIDER NUMBER, CURRENT PATIENT Yes or No, CHILD OVER 19. Rows include EMPLOYEE, SPOUSE, CHILD #1-4.

1 If enrollment is for Personal Care Plan or MedPoint coverage, you must select a primary care physician from the provider directory provided in your enrollment package. If you do not select one, one will be assigned to you in order to process your application and enroll you for membership.
2 Attach a copy of the legal documentation concerning the child's health care coverage.

E. PRIOR INSURANCE INFORMATION

This section MUST be completed to receive credit for prior coverage and REDUCE or ELIMINATE any waiting period before benefits become active and claims are processed. IF YES, complete below. Have you had any health insurance within the last 63 days? Yes No

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY, POLICY NUMBER, POLICY HOLDER AND DATE OF BIRTH, EFFECTIVE DATE, TERMINATION DATE, 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#

F. COORDINATION WITH OTHER INSURANCE COMPANIES

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

NAME, ADDRESS AND PHONE NUMBER OF OTHER HEALTH INSURANCE COMPANY, POLICY HOLDER NAME AND DATE OF BIRTH, POLICY HOLDER'S EMPLOYER, ADDRESS AND PHONE NUMBER, POLICY HOLDER SOCIAL SECURITY NUMBER, POLICY NUMBER, EFFECTIVE DATES OF COVERAGE, 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.

USE EXTRA PAPER IF MORE THAN ONE ADDITIONAL POLICY WILL BE IN FORCE. BCBSNC ONLY, TIER (Current), TIER (Change), DATE PROCESSED, PROCESSED BY, PACKAGE.

G. HEALTH QUESTIONS

Please complete this section if you are an employee of a group with fewer than 25 employees enrolled.

PLEASE ANSWER EACH HEALTH QUESTION LISTED BELOW. IF THE ANSWER IS YES, PLEASE PROVIDE ADDITIONAL INFORMATION IN ITEM 8.

1. Has any person applying for coverage ever sought medical attention and/or advice, been diagnosed with or been treated for any of the following conditions within the past 10 years (This includes conditions present today.):

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Aids (acquired immune deficiency syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	Disorders of joints	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
HIV (human immunodeficiency virus)	<input type="checkbox"/>	<input type="checkbox"/>	Specify location and condition _____			How Long _____		
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Disorder of reproductive system	<input type="checkbox"/>	<input type="checkbox"/>	Last 3 readings _____		
Arthritis (rheumatoid)	<input type="checkbox"/>	<input type="checkbox"/>	Specify condition _____			Medications _____		
Arthritis (other _____)	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependency, abuse	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid, goiter, pituitary or adrenal gland disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, allergies or other breathing condition	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema, COPD, Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, kaposi's sarcoma, or other malignant tumor.	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Last level _____		
Colitis or intestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>	Date of last seizure _____			Headaches (severe), migraines	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease or regional enteritis	<input type="checkbox"/>	<input type="checkbox"/>	Type of seizure/epilepsy _____			Ulcers, stomach or other digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease, gall stones	<input type="checkbox"/>	<input type="checkbox"/>	Specify condition _____		
Insulin _____			Kidney disease, kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins, thrombosis, leg ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Oral Medication _____			Heart disease, angina, heart attack coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	Disorders of veins or arteries	<input type="checkbox"/>	<input type="checkbox"/>
Diet Controlled _____			Specify condition _____			Anemia or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diseases of eyes, ears, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, TIA	<input type="checkbox"/>	<input type="checkbox"/>	Specify type _____		
Specify condition _____			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Mental conditions, depression, anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of spine, discs, back	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system disorder or brain damage	<input type="checkbox"/>	<input type="checkbox"/>
Specify condition _____			Specify type _____			Specify condition _____		
Paralysis, neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hernia or prostate disorder	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Sclerosis, Cerebral Palsy, Parkinsons disease, Alzheimers disease	<input type="checkbox"/>	<input type="checkbox"/>
			Birth defect or deformity	<input type="checkbox"/>	<input type="checkbox"/>	(circle which)		

Any other condition not noted above? YES NO
Specify condition(s) _____

2. Has any person to be covered experienced any condition for which future consultation, treatment, or surgery is contemplated or advised? YES NO

3. Has any person to be covered taken prescription medication within the last 12 months, including today? YES NO
If **yes**, please list:
Name _____ Date of Onset _____
Medication _____
Condition/Reason Taking _____
Name _____ Date of Onset _____
Medication _____
Condition/Reason Taking _____

6. Has any person to be covered smoked cigarettes, cigars, pipes or used tobacco such as chewing? YES NO
If **yes**, please indicate:
Name(s) _____
Form of Tobacco _____
Amount Used Daily _____
Number of Years Used _____
Date of Last Use, If Quit _____

4. Has any person to be covered ever been declined for health coverage or been issued an exclusion rider for a specific condition? YES NO

7. Does any person to be covered consume alcohol? YES NO
If **yes**, please indicate approximately how many drinks per week:
Name _____ Drinks per Week _____
Name _____ Drinks per Week _____

5. Are you, your spouse, or any dependent, (whether or not applying) currently pregnant or an expectant parent? YES NO

8. FOR EACH ITEM CHECKED "YES" IN SECTIONS 1 OR 2, PLEASE EXPLAIN BELOW. (If more space is needed, attach a separate sheet.)

1. NAME OF PERSON	CONDITION OR DIAGNOSIS	DATE OF ONSET	DEGREE OF RECOVERY AND DATE OF LAST TREATMENT
DETAILS OF TREATMENT AND MEDICATIONS		NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN	
2. NAME OF PERSON	CONDITION OR DIAGNOSIS	DATE OF ONSET	DEGREE OF RECOVERY AND DATE OF LAST TREATMENT
DETAILS OF TREATMENT AND MEDICATIONS		NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN	
3. NAME OF PERSON	CONDITION OR DIAGNOSIS	DATE OF ONSET	DEGREE OF RECOVERY AND DATE OF LAST TREATMENT
DETAILS OF TREATMENT AND MEDICATIONS		NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN	

9. HEIGHT AND WEIGHT

APPLICANT'S		SPOUSE'S		CHILD #1		CHILD #2		CHILD #3		CHILD #4	
HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT

Statement of Understanding and Authorization

I understand that the benefits for which I (we) will be eligible are those described in the group contract and any changes provided for therein.

I authorize any medical professional, medical care institution, or other provider of health care services or supplies to furnish to BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA ("BCBSNC") information concerning services or supplies provided to me or any family member. I understand that this information will be used for the purposes of determining eligibility for coverage, review, investigation, or payment of a claim and review of records for quality improvement initiatives. Such records may be reviewed by third party quality review organizations. I authorize any prior insurance carrier to furnish information concerning my and/or my dependent's prior insurance coverage including the type of coverage provided, the effective date and/or the termination date of the insurance coverage provided me and my eligible family members. The authorization is valid for 30 months for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with review of claims.

I understand that BCBSNC 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.

AGREEMENT: I HAVE READ AND AGREE TO THE TERMS OF THE MEMBER CERTIFICATE AND THE INFORMATION ON THIS FORM.

Employee Signature: _____ Date: _____