

CHECK BOX:

- ENROLLMENT FORM - New Members: Complete all items in Sections B, C, D, E, F.
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.
DATE OF OCCURRENCE:
CANCEL CERTIFICATE: CANCEL DEPENDENT(S): Marriage, Divorce, Separation, Age Limit, Death, Other.
DATE OF OCCURRENCE:
COBRA: Elect COBRA, Effective Date.
REINSTATEMENT: Return from Layoff, Return from Leave, Retire, Disenrollment Error, Other.
COBRA QUALIFYING EVENT: Death, Termination of Employment, Reduction in Hours, Divorce, Separation, Medicare Eligibility, Social Security Disability Determination, Overaged Dependent Now Ineligible.

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, Preferred Care Select, Comp. Major Medical, Dental, Vision, PACKAGE NUMBER.
CHECK ONE: Employee Only, Employee/Spouse, Employee/Child, Employee/Children, Family, Other.

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 for EMPLOYEE, SPOUSE, CHILD #1, CHILD #2, CHILD #3.

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 of the following two questions, complete below.

Are any dependents 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, Disability, Age, PART A EFFECTIVE DATE, PART B EFFECTIVE DATE.

AGREEMENT: I have read and agree to the terms of the member certificate and the information on the reverse side of this form.

USE EXTRA PAPER IF MORE THAN ONE ADDITIONAL POLICY WILL BE IN FORCE.

BCBSNC ONLY, TIER (Current) SGL, FAM, TP, ECH, ES, EC, TIER (Change) SGL, FAM, TP, ECH, ES, EC, DATE PROCESSED, PROCESSED BY, PACKAGE

## **G. PLEASE READ**

### **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.