

# PostDoc Blue Options Dependent Insurance Application Form North Carolina State University 2010-2011

Please visit our web site at [bcbsnc.com/NCSU](http://bcbsnc.com/NCSU)

PLEASE PRINT CLEARLY.

## Section I PostDoc Blue Options Dependent Application Form\*

LAST NAME	FIRST NAME	BIRTHDATE	MIDDLE INITIAL	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
MAILING ADDRESS (STREET, ROUTE, BOX NUMBER, ETC.)					
CITY	STATE	ZIP	SOCIAL SECURITY NUMBER		
E-MAIL ADDRESS					
DEPARTMENT AFFILIATION		AREA CODE	TELEPHONE NUMBER		

\*Please see the legal notice on the reverse side of this application regarding special enrollment.

## Section II Application for Dependents' Coverage\*

I also hereby apply for the following members of my family:

<b>SPOUSE</b>					SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE		
SOCIAL SECURITY NUMBER					MONTH DAY YEAR
<b>CHILD 1</b>					SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE		
SOCIAL SECURITY NUMBER					MONTH DAY YEAR
<b>CHILD 2</b>					SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE		
SOCIAL SECURITY NUMBER					MONTH DAY YEAR
<b>CHILD 3</b>					SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE		
SOCIAL SECURITY NUMBER					MONTH DAY YEAR

\*DEPENDENTS INCLUDE SPOUSE AND UNMARRIED DEPENDENT CHILDREN FROM BIRTH TO THE 26<sup>th</sup> BIRTHDAY

## Section III Premiums

<input type="checkbox"/> Spouse..... \$ 259.75 per month	My check for \$ _____ is enclosed.
<input type="checkbox"/> Child/Children ..... \$ 151.48 per month	Please make check payable to: Blue Cross and Blue Shield of North Carolina

The PostDoc's insurance premiums and PostDoc health fee will be paid by the University. Additional monthly premiums to cover dependents will be drafted from your bank account (see Section VI).

## Section IV Prior Insurance Information

**It is very important that you provide all relevant information in full. Failure to do so may hinder processing of your claims.**

I was covered under the North Carolina State University student plan provided by Blue Cross and Blue Shield of North Carolina (BCBSNC) during the 2009-2010 policy year.

I have had no health insurance within the last 63 days.\*

I am currently covered, or have been covered within the past 63 days, by the following health insurance plan. BCBSNC may request a HIPAA certificate for verification purposes.

PREVIOUS INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

AREA CODE TELEPHONE NUMBER POLICY NUMBER

EFFECTIVE DATE OF POLICY TERMINATION DATE OF POLICY

EMPLOYER (if applicable) MONTH DAY YEAR MONTH DAY YEAR

Please check here if the above information is the **same** for all dependents listed on policy.

Please check here if one or more dependents listed have **different** previous insurance information. A letter outlining each dependent's previous insurance information **must** be attached.

\*Please see the legal notice on the reverse side of this application regarding coverage of pre-existing conditions.

## Section V Statement of Understanding

I understand that by signing below, I am agreeing to the following:

I certify that all statements on this application are complete and true. I understand that for a period of two years from the date coverage is issued, Blue Cross and Blue Shield of North Carolina (BCBSNC) may void or terminate my 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 understand that any coverage provided according to this application will be subject to the provisions of the contract including the benefit booklet provided to me by BCBSNC.

I have read and understand the legal notices on the reverse side regarding coverage of pre-existing conditions and special enrollment.

SIGNATURE OF PRIMARY APPLICANT DATE

MONTH DAY YEAR

## Section VI Monthly Bank Draft

**IMPORTANT: Please enclose a check marked "VOID" for the account from which funds are to be drafted.**

**At enrollment, you must pay the first two monthly premiums directly to Blue Cross and Blue Shield of North Carolina.**

If your appointment date is the first of the month, your first bank draft will take place two months after your effective date. That draft and all subsequent drafts will take place on the first business day of the month.

If your appointment date is any day other than the first of the month, your first bank draft will take place on the first day of your third full month of employment. For example, if your appointment date is September 5, 2010, the first bank draft would take place on December 1, 2010. That draft and all subsequent drafts will take place on the first business day of the month.

I hereby authorize the North Carolina State University Postdoc Medical Insurance Plan to draft funds from my account for the premiums to cover my dependents under the North Carolina State University Postdoc Medical Insurance Plan.

SIGNATURE OF ACCOUNT HOLDER DATE

MONTH DAY YEAR

**Mailing Address: Blue Cross and Blue Shield of North Carolina P.O. Box 9565 Chapel Hill, NC 27515-9565**  
**Questions? Call Student Blue at 919-645-0240 or email@studentbluenc.com**

## **IMPORTANT LEGAL NOTICES 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 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 (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 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, or within 60 days after the loss of Medicaid or Children's Health Insurance Program (CHIP) eligibility for you and your dependents.

For questions or to obtain more information, contact:

**Blue Cross and Blue Shield of North Carolina**  
P.O. Box 9565 Chapel Hill, NC 27515-9565  
**919-645-0240**

## **COVERAGE OF PRE-EXISTING CONDITIONS**

This plan imposes a pre-existing condition exclusion. 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 children added as a result of a court order, or 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 and foster children) 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 us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we 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 Blue Cross and Blue Shield of North Carolina if you need help demonstrating creditable coverage. Throughout this notice: all references to "you" are meant to refer to the subscriber and their dependents, and all references to "us" and "we" are meant to refer to Blue Cross and Blue Shield of North Carolina.

For questions or to obtain more information, contact:

**Blue Cross and Blue Shield of North Carolina**  
P.O. Box 9565 Chapel Hill, NC 27515-9565  
**919-645-0240**