

# PostDoc Blue Options Dependent Insurance Application Form North Carolina State University 2011-2012

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				
STUDENT I.D. NUMBER				
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:

**SPOUSE** SEX  MALE  FEMALE

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE
SOCIAL SECURITY NUMBER			
MONTH		DAY	YEAR

**CHILD 1** SEX  MALE  FEMALE

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE
SOCIAL SECURITY NUMBER			
MONTH		DAY	YEAR

**CHILD 2** SEX  MALE  FEMALE

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE
SOCIAL SECURITY NUMBER			
MONTH		DAY	YEAR

**CHILD 3** SEX  MALE  FEMALE

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE
SOCIAL SECURITY NUMBER			
MONTH		DAY	YEAR

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

## Section III Premiums

Spouse..... \$ 246.13 per month      My check for \$ \_\_\_\_\_ is enclosed.

Child/Children ..... \$ 179.00 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 BCBSNC during the 2010-2011 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		
MONTH		DAY
YEAR		TERMINATION DATE OF POLICY
MONTH		DAY
YEAR		

EMPLOYER (if applicable)

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 of this application, Blue Cross and Blue Shield of North Carolina (BCBSNC) may rescind my policy for any acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. 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, 2011, the first bank draft would take place on December 1, 2011. 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 (including Medicaid or Children's Health Insurance Program (CHIP)) 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 (other than Medicaid or CHIP) or if the employer stops contributing towards your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility. 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.

For questions or to obtain more information, contact:

**Blue Cross and Blue Shield of North Carolina**  
PO Box 9565, Chapel Hill, NC 27515-9565  
or call **800-579-8022**

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

This plan imposes a pre-existing condition exclusion for you and your dependents age 19 and over. 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 or members under age 19. 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**  
PO Box 9565, Chapel Hill, NC 27515-9565  
or call **800-579-8022**