BlueCross BlueShield of North Carolina

PostDoc Blue Options Dependent Insurance Application Form

University of North Carolina 2009-2010

Please visit our web site at ***bcbsnc.com/UNC***

PLEASE PRINT CLEARLY.

Section I — PostDoc Blue Options Dependent Application Form*

LAST NAME | FIRST NAME | MIDDLE INITIAL

BIRTHDATE: MONTH | DAY | YEAR

SEX: ☐ MALE ☐ FEMALE

MAILING ADDRESS *(STREET, ROUTE, BOX NUMBER, ETC.)*

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER *(Required)*

EMAIL ADDRESS

P.I.D. NUMBER *(Optional)*

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

FIRST NAME | INITIAL | LAST

BIRTHDATE: MONTH | DAY | YEAR

SOCIAL SECURITY NUMBER

CHILD 1

SEX: ☐ MALE ☐ FEMALE

FIRST NAME | INITIAL | LAST

BIRTHDATE: MONTH | DAY | YEAR

SOCIAL SECURITY NUMBER

CHILD 2

SEX: ☐ MALE ☐ FEMALE

FIRST NAME | INITIAL | LAST

BIRTHDATE: MONTH | DAY | YEAR

SOCIAL SECURITY NUMBER

CHILD 3

SEX: ☐ MALE ☐ FEMALE

FIRST NAME | INITIAL | LAST

BIRTHDATE: MONTH | DAY | YEAR

SOCIAL SECURITY NUMBER

DEPENDENTS INCLUDE SPOUSE AND UNMARRIED DEPENDENT CHILDREN FROM BIRTH TO THE 26TH BIRTHDAY

Section III — Premiums

☐ Spouse.. $ 166.64 per month + Campus Health Fee

☐ Child/Children .... $ 117.43 per month

C254PD-DepUNC, 4/09

APPLICATION IS CONTINUED ON THE REVERSE SIDE.

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 University of North Carolina student plan provided by Blue Cross and Blue Shield of North Carolina (BCBSNC) during the 2008-2009 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

EMPLOYER *(if applicable)*

EFFECTIVE DATE OF POLICY: MONTH | DAY | YEAR

TERMINATION DATE OF POLICY: 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 of this application regarding coverage of pre-existing conditions and special enrollment.

SIGNATURE OF PRIMARY APPLICANT

DATE: MONTH | DAY | YEAR

Section VI — Payroll Deduction

For PostDocs insuring their dependents beginning July 1, 2009, please submit a check for two (2) months for the period beginning July 1, 2009 through August 31, 2009. A payroll deduction will be made on August 31, 2009 for the period beginning September 1, 2009 through September 30, 2009. Deductions will continue each month throughout the Postdoctoral appointment. For PostDocs insuring dependents beginning after July 1, 2009, please provide a check for the first two (2) months. Additional monthly deductions will be made through payroll.

I hereby authorize the University of North Carolina to deduct from my salary/wages my premium applicable to the enrollment of my dependents in the University of North Carolina PostDoc Medical Insurance Plan.

SIGNATURE

DATE: MONTH | DAY | YEAR

DEPARTMENT AFFILIATION

Mailing Address: Blue Cross and Blue Shield of North Carolina, P.O. Box 3617, Chapel Hill, NC 27515-3617

Questions? Call Student Blue at 919-967-5900 or email@studentbluenc.com

Blue Cross and Blue Shield of North Carolina is an Independent Licensee of the Blue Cross and Blue Shield Association

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 3617 Chapel Hill, NC 27515-3617

919-967-5900

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:

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