

Section I Application for Dependents' Coverage**

I 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 26th BIRTHDAY

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

Section II Student Medical Insurance Application Form

LAST NAME FIRST NAME MIDDLE INITIAL

BIRTH DATE MONTH DAY YEAR

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

CITY STATE ZIP

SEX MALE FEMALE

SOCIAL SECURITY NUMBER (Required)

STUDENT I.D. OR P.I.D. NUMBER (Optional)

AREA CODE TELEPHONE NUMBER

EMAIL ADDRESS

Section III Premium Rate Selection

SPOUSE ANNUAL

CHILD/CHILDREN SEMI-ANNUAL

(Number: _____) MONTHLY BANK DRAFT (not available after: September 30, 2011)

My check for \$ _____ is enclosed. Make check payable to Blue Cross and Blue Shield of North Carolina.

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 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 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 by signing below, I am agreeing to the following:
I certify that I have read and understand the "Student Blue Options" brochure section entitled "Eligibility", and that I am eligible for student coverage.

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 of this application 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. Option not available after September 30, 2011.

Premiums will be divided into nine equal payments. At enrollment, student must pay the first two payments. The seven monthly bank draft payments will begin on October 30, 2011, and continue through April 30, 2012.

I hereby authorize the University of North Carolina Student Medical Insurance Plan to draft funds from my account beginning October 30, 2011, through April 30, 2012. (Exception: The February draft will occur on February 28, 2012.)

SIGNATURE OF ACCOUNT HOLDER DATE MONTH DAY YEAR

PLEASE PRINT NAME MONTH DAY YEAR

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

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:

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