

ENROLLMENT AND CHANGE APPLICATION *with health questions*

CHANGE REQUEST:

For changes, complete sections A, B, and all other applicable sections

Instructions: ALL new Employees Complete **B, C, D, E, F, H**
If your group has selected any Life Products also complete and provide your signature in **G**

COMPLETED BY GROUP ADMINISTRATOR ONLY			
Effective Date	MM	DD	YYYY
Group Number			
Package Number			
Dept/Division/Class			

Please type or print in black or blue, NOT RED ink

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

Check All That Apply: <input type="checkbox"/> Name Change <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Address Change <input type="checkbox"/> Other Insurance Information <input type="checkbox"/> Telephone Change <input type="checkbox"/> Replace ID Card <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> E-Mail Address <input type="checkbox"/> Other _____ _____ _____	Add Dependent(s): <input type="checkbox"/> Marriage <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Newborn <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Adoption <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Other _____ <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table>	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	Reinstate Coverage: Reason: _____ _____ _____											
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Remove Dependent(s): <input type="checkbox"/> Marriage <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Divorce <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Student Status <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Death <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Other _____ <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table>	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	Cancel Coverage: <input type="checkbox"/> Not Eligible <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Left Employment <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Subscriber Request <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> <input type="checkbox"/> Other Reason: _____ _____ _____	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY
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B. EMPLOYEE INFORMATION

<input type="checkbox"/> ACTIVE EMPLOYEE	<input type="checkbox"/> COBRA/STATE CONTINUATION:									
COBRA/State Continuation Qualifying Event:	<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Divorce <input type="checkbox"/> Over Age Dependent <input type="checkbox"/> Medicare Eligible									
What was the date of the Qualifying Event? <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table>	MM	DD	YYYY	Date Continuation Started <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table> Date Continuation Ends <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table>	MM	DD	YYYY	MM	DD	YYYY
MM	DD	YYYY								
MM	DD	YYYY								
MM	DD	YYYY								
First Name	Middle Initial	Last Name	Suffix							
Employee Social Security Number		Employee Birthdate <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table>		MM	DD	YYYY				
MM	DD	YYYY								
Address	Apt. No.	City	State	Zip Code						
<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Height	Weight							
Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.) <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Choose not to report <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Other (specify) _____										
Company Name		Occupation								
Work Location	Date of Full Time Employment <table border="1"><tr><td>MM</td><td>DD</td><td>YYYY</td></tr></table>	MM	DD	YYYY	Language Preference <input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other _____					
MM	DD	YYYY								
Work Phone Number ()	Home Phone Number ()									
Your E-Mail Address (optional)										

Application Continued on Next Page →

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BlueCross BlueShield of North Carolina

C. COVERAGE SELECTION – Complete for BCBSNC Health and Dental

Coverage (Check only one medical plan):	<input type="checkbox"/> Blue Care® (HMO)	<input type="checkbox"/> Classic Blue® (CMM)	<input type="checkbox"/> Blue Options 1-2-3
	<input type="checkbox"/> Blue Options SM (PPO)	<input type="checkbox"/> Blue Options HSA SM	<input type="checkbox"/> Dental Blue
<input type="checkbox"/> MEDICAL BENEFITS SELECTED:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> No Medical Benefits
	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Family	
<input type="checkbox"/> DENTAL BENEFITS SELECTED:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> No Dental Benefits
	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Family	

D. FAMILY INFORMATION – Complete for Anyone Taking Medical and/or Dental Coverage

- List family members taking medical or dental.
- Student status and handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents.

NAME First, Middle Initial, Last, Suffix	Social Security Number	Marital Status	Birthdate	Sex	H E I G H T	W E I G H T	H E A L T H	D E N T A L	If Child Is Over Age 19, Please Indicate Status And School Name	Child Status (if applicable)
Spouse		<input type="checkbox"/> Single <input type="checkbox"/> Married	mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
Child 1		<input type="checkbox"/> Single <input type="checkbox"/> Married	mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-Time Student At: _____	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted
Child 2		<input type="checkbox"/> Single <input type="checkbox"/> Married	mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-Time Student At: _____	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted
Child 3		<input type="checkbox"/> Single <input type="checkbox"/> Married	mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-Time Student At: _____	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted

*If you have more than three children, complete **Section D** on another application.

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH/DENTAL INSURANCE INFORMATION

E1. PRIOR HEALTH/DENTAL INSURANCE

*This section **MUST** be completed to receive credit for prior coverage and **REDUCE** or **ELIMINATE** any applicable waiting period.*

Have you had any health insurance within the last sixty-three (63) days? Yes No **If YES, complete the following:**

Name of Health Insurance Company		Address						
Phone Number ()	Policy Number	Policyholder Date of Birth	MM	DD	YYYY			
Policyholder First Name		Policyholder Last Name						
If other coverage will remain in effect, write N/A in term box and complete section below.	Effective Date	MM	DD	YYYY	Termination Date or Expected Termination Date	MM	DD	YYYY

Family Members Covered **List FIRST and LAST Names:**

Have you or any family dependents been a previous Blue Cross and Blue Shield of North Carolina member? Yes No

Names, Dates and ID Numbers

Do you have prior dental insurance? (If yes, attach a certificate of creditable coverage to this application.) Yes No

Notice About Your Pre-Existing Condition Limitations

This plan imposes a pre-existing condition exclusion for all employees and dependents whether they are timely or late enrollees. 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 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, foster children, and those added as a result of a court order) 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

Employee Name:

experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give BCBSNC a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, BCBSNC 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 BCBSNC if you need help demonstrating creditable coverage. Throughout this notice, all references to "you" are meant to refer to both the employee and their dependents.

Notice of 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 your 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" or any longer period that applies under the plan 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" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption or foster care.

For questions or to obtain more information, contact a BCBSNC Customer Service Representative at:

Blue Cross and Blue Shield of North Carolina Customer Service
1-877-258-3334

E2. OTHER HEALTH INSURANCE

This section MUST be completed if you will have additional insurance in force during this new policy.

Will you or your covered dependents have other insurance in addition to this policy? Yes No

Are any dependents covered under another plan due to divorce/separation? Yes No If YES to either question, complete the following:

Name of Health Insurance Company Policyholder First Name Middle Initial Last Name

Policy Number Policyholder Date of Birth MM DD YYYY If Individual coverage CHECK HERE

Effective Dates of Coverage: FROM: MM DD YYYY TO: MM DD YYYY

Individuals Covered (List FIRST and LAST names):

Family Members Covered by Medicare (List FIRST and LAST names):

Medicare Claim Number Is Medicare Eligibility Due to: Part A Effective Date: Part B Effective Date:

F. HEALTH QUESTIONS

All questions in this Section (Section F) MUST be answered in their entirety. Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information. Please use "Month/Day/Year" where required.

PLEASE NOTE: "Section F.2" information is required for all disorders with a "YES" answer.

Has any person applying for coverage sought medical attention and/or advice, been diagnosed with or been treated for any of the following diseases or disorders (this includes diseases or disorders past and present):

Table with 2 columns of disorders and YES/NO checkboxes. Disorders include heart attack, hypertension, emphysema, hepatitis, muscular dystrophy, chronic fatigue, depression, etc.

DISORDER	YES	NO
17. Joint replacement, or recommended joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>
a. Primary - Date of surgery: <u>MM</u> <u>DD</u> <u>YYYY</u>		
b. Spouse - Date of surgery: <u>MM</u> <u>DD</u> <u>YYYY</u>		
18. Arthritis, such as inflammatory arthritis, rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis?	<input type="checkbox"/>	<input type="checkbox"/>
19. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
a. Primary - Date of diagnosis: <u>MM</u> <u>DD</u> <u>YYYY</u>		
b. Spouse - Date of diagnosis: <u>MM</u> <u>DD</u> <u>YYYY</u>		
c. What is your most recent hemoglobin A1C (HGBA1C) reading taken by your doctor? Primary: _____ Spouse: _____		
20. Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
21. Within the last 5 years has anyone been diagnosed with cancer or had cancer surgery, radiation therapy or chemotherapy for:		
a. Cancer/malignancy, including melanoma?	<input type="checkbox"/>	<input type="checkbox"/>
b. Other forms of skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>
22. Prostate disorders, including enlarged prostate, benign prostatic hypertrophy or elevated readings?	<input type="checkbox"/>	<input type="checkbox"/>
23. Bleeding disorder, such as Hemophilia or Von Willebrand's?	<input type="checkbox"/>	<input type="checkbox"/>
24. Sickle cell anemia, aplastic anemia or thalassemia major?	<input type="checkbox"/>	<input type="checkbox"/>
25. Moderate or severe psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>
26. Sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>
27. Epilepsy or seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
a. If yes, was the most recent seizure within the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
28. Has anyone who is less than 12 years of age had more than 3 ear infections in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
29. Has anyone ever had the following procedures or treatments performed:		
a. Spinal fusion?	<input type="checkbox"/>	<input type="checkbox"/>
b. Gastric bypass or gastric restrictive procedures, such as lap band?	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart valve replacement?	<input type="checkbox"/>	<input type="checkbox"/>
d. Currently in treatment/therapy for ligament or tendon repair of knee or shoulder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Cerebral shunt placement?	<input type="checkbox"/>	<input type="checkbox"/>
f. Permanent colostomy/ileostomy?	<input type="checkbox"/>	<input type="checkbox"/>
g. Surgery related to gastro esophageal reflux disorder (GERD)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Any internal organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
i. Kidney dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
j. Any past surgical procedure resulting in complications that still require treatment?	<input type="checkbox"/>	<input type="checkbox"/>
30. Has anyone been advised or scheduled to have surgery within the next 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
31. Within the last 12 months, has anyone seen an allergist or received an immuno-therapy injection?	<input type="checkbox"/>	<input type="checkbox"/>
32. Has anyone been treated within the last 2 years for an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
33. Has anyone seen a chiropractor or physical therapist more than 5 times in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
a. Primary - Date of your last visit: <u>MM</u> <u>DD</u> <u>YYYY</u>		
b. Spouse - Date of your last visit: <u>MM</u> <u>DD</u> <u>YYYY</u>		
34. Has anyone had any treatment in the last year for disc disorder of back or neck including surgery or injection therapy other than chiropractic care or physical therapy?	<input type="checkbox"/>	<input type="checkbox"/>
35. More than 2 breast biopsies in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
36. Within the past 12 months, has anyone had any treatment for heavy, frequent, AND prolonged periods; uterine fibroids; or endometriosis; but have NOT had total abdominal hysterectomy (TAH)?	<input type="checkbox"/>	<input type="checkbox"/>
37. Have either of your last two pap smears been abnormal?	<input type="checkbox"/>	<input type="checkbox"/>

DISORDER	YES	NO
38. Does anyone exercise for at least 20 minutes per day 3 or more times per week?	<input type="checkbox"/>	<input type="checkbox"/>
39. Within the last 12 months, has anyone smoked cigarettes, marijuana, cigars, pipes or used chewing tobacco or snuff?	<input type="checkbox"/>	<input type="checkbox"/>
40. Has anyone applying for coverage on this application been prescribed or advised to use or taken any of the following categories of prescription medications within the last 12 months?		
a. Anti-depressant?	<input type="checkbox"/>	<input type="checkbox"/>
b. Anti-psychotic?	<input type="checkbox"/>	<input type="checkbox"/>
c. Anti-anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
d. Attention deficit (ADD) or attention deficit hyperactivity (ADHD) medication?	<input type="checkbox"/>	<input type="checkbox"/>
e. Antabuse or other medications used in the treatment of alcoholism?	<input type="checkbox"/>	<input type="checkbox"/>
f. Migraine medication?	<input type="checkbox"/>	<input type="checkbox"/>
g. Tracleer?	<input type="checkbox"/>	<input type="checkbox"/>
h. Blood thinner/anti-coagulant medication?	<input type="checkbox"/>	<input type="checkbox"/>
i. Nitroglycerin, Digoxin or Lanoxin?	<input type="checkbox"/>	<input type="checkbox"/>
j. Immunosuppressive medication, such as, Methotrexate, Imuran, Cytoxin?	<input type="checkbox"/>	<input type="checkbox"/>
k. Oral steroids taken or prescribed for use every day all year, or oral steroids or steroid injections taken for an ongoing condition requiring usage at least 3 times a year?	<input type="checkbox"/>	<input type="checkbox"/>
l. Plaquenil/Hydroxychloroquine?	<input type="checkbox"/>	<input type="checkbox"/>
m. Growth hormones such as: Humotrope, Genotropin, Nutropin, Norditropin?	<input type="checkbox"/>	<input type="checkbox"/>
n. Gastrointestinal medication, such as Nexium?	<input type="checkbox"/>	<input type="checkbox"/>
o. Injection medication for rheumatoid arthritis, psoriasis, inflammatory bowel disease, ulcerative colitis or Crohn's Disease such as Arava?	<input type="checkbox"/>	<input type="checkbox"/>
p. Remicade?	<input type="checkbox"/>	<input type="checkbox"/>
q. Enbrel?	<input type="checkbox"/>	<input type="checkbox"/>
r. Infertility medication?	<input type="checkbox"/>	<input type="checkbox"/>
s. Pancreatic enzymes used in the treatment of Cystic Fibrosis, such as, Creon, Pancrease, Ultrase, Lipram?	<input type="checkbox"/>	<input type="checkbox"/>
t. Synagis?	<input type="checkbox"/>	<input type="checkbox"/>
We need to know only about medications that are specified in Question 40. Please do not list any other medications.		
41. Does anyone have a physical or mental impairment that substantially limits one or more major life activities: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working?	<input type="checkbox"/>	<input type="checkbox"/>
Describe each such physical or mental impairment and identify the person with such physical or mental impairment: _____		
Please describe how the physical or mental impairment substantially limits one or more of the major life activities stated previously: _____		

If yes, is the physical or mental impairment temporary or correctable?		

If yes, please explain how the physical or mental impairments are temporary or how the person plans to have it corrected: _____		

42. Is anyone aware of any symptoms or conditions that have not yet been diagnosed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list them: _____		

43. Does anyone have any other conditions or symptoms for which no question was provided?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list them: _____		

Employee Name:

F2. For each item checked "YES" in the previous Section, please provide condition or diagnosis for each person.

	Person #1 Name:	Person #2 Name:	Person #3 Name:
Condition or Diagnosis:			

If additional space is needed, please attach a separate sheet, with your signature and the date (mm/dd/yyyy).

G. COVERAGE SELECTION Underwritten by USABLE Life (if offered by employer)

Coverage Selection:

Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

Life/AD&D Yes No

Dependent Life Yes No

Weekly Disability Yes No

Long Term Disability Yes No

Supplemental Life/AD&D Yes No Amount: _____

No Benefits Selected

Employee's Annual Salary

Primary Beneficiary Name (required)	Primary Beneficiary Address (required)
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Relationship	Date of Birth	MM	DD	YYYY	Social Security Number	Percent ¹
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Second Primary Beneficiary Name (required)	Second Primary Beneficiary Address (required)
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Relationship	Date of Birth	MM	DD	YYYY	Social Security Number	Percent ¹
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Contingent Beneficiary Name (required)	Contingent Beneficiary Address (required)
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Relationship	Date of Birth	MM	DD	YYYY	Social Security Number	Percent ¹
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Second Contingent Beneficiary Name (required)	Second Contingent Beneficiary Address (required)
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Relationship	Date of Birth	MM	DD	YYYY	Social Security Number	Percent ¹
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¹ NOTE: the primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I selected any of the products listed in this section that I will be covered by USABLE Life.
- I understand that if I am not actively at work as defined in the policy(ies) (for the products selected above) on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

X Signature: _____ Date

MM	DD	YYYY
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H. STATEMENT OF UNDERSTANDING

I understand that the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina and/or the life insurance carrier contract and any changes provided for therein.

I understand that BCBSNC and/or the life insurance carrier 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.

BLUE OPTIONS HSA PLANS ONLY:

I understand that if I am applying for Blue Options HSA, the HSA is provided to me directly by a separate administrator, unaffiliated with Blue Cross and Blue Shield of North Carolina (BCBSNC). BCBSNC is not responsible or liable for administration of the HSA. Detailed information regarding my HSA will be provided by that administrator. I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.

I understand that if my employer chooses select administrators for my HSA, my employer or their designees will share certain personal information about me with such administrators to facilitate the administrator's establishment of the HSA account. By signing this application, I authorize my employer or their designees to share pertinent information with these select administrators as applicable, which may include my name, address, social security number and my employer's name.

I understand that if issued a debit card in connection with my HSA, I agree that although BCBSNC's name and marks may be included on the face of the debit card for convenience, BCBSNC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.

I understand that BCBSNC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my BCBSNC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.

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.

X Signature: _____ Date

MM	DD	YYYY
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I. STATEMENT OF AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that if I refuse to sign this authorization that BCBSNC may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

- (i) my past, present, or future physical or mental health or condition;
- (ii) the provision of health care to me; or
- (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to Blue Cross and Blue Shield of North Carolina ("BCBSNC").

I further authorize BCBSNC to review any applications for health care coverage that I may have submitted to BCBSNC in the past.

I authorize BCBSNC to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that BCBSNC will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that BCBSNC will make every effort to safeguard my protected health information. I further understand that BCBSNC will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require BCBSNC to disclose my protected health information. I understand that BCBSNC may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

Rating
Blue Cross and Blue Shield of North Carolina
P.O. Box 30013
Durham, NC 27702

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

- (i) for information that BCBSNC already used or disclosed, relying on this authorization or
- (ii) if the authorization was obtained as a condition of coverage in BCBSNC and, by law, BCBSNC has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below. After 120 days expire, BCBSNC may no longer use this information.

Signature of Primary Applicant or Legal Personal Representative: _____ Date

MM	DD	YYYY
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Name of Legal Personal Representative (please print): _____

Description of Legal Personal Representative's Authority: _____