

Enrollment/Change Application

Completed by Group Administrator Only	
Group Number (if applicable):	Life Class Designation (if applicable):

Instructions:

- All employees applying for medical coverage complete Sections **A, B** (if applicable), **C** (if applicable), **D, E, F, H, I**.
- For change requests, complete Sections **A, C** and all other applicable sections.
- If declining medical coverage, please complete Sections **A** and **D**.
- For help in reading this notice, BCBSNC provides consumer assistance tools and services for individuals living with disabilities (including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. BCBSNC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call **877-258-3334**. For TTY and TDD, call **800-442-7028**.

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

A. Employee information

First Name		Middle Initial	Last Name		Suffix	
Employee Birthdate	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy	Employee Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status
Address		P.O. Box <small>(For Blue Options HSA you must also provide a street address.)</small>	Apt. No.	City	State	Zip Code
Company Name			Occupation			
Work Location	Date of Full Time Employment	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy	Language Preference <input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other _____	
Home Phone Number ()	Work Phone Number ()		E-Mail Address			

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.)

- African American/Black
 Asian/Asian American
 Choose not to report
 White/Caucasian
 Hispanic/Latino
 Native American/Alaskan Native
 Other (specify) _____

- ACTIVE EMPLOYEE
 COBRA/STATE CONTINUATION

COBRA/State Continuation Triggering Event:
 Termination of Employment
 Reduction in Hours
 Death of Subscriber
 Divorce
 Over Age Dependent
 Medicare Eligible

What was the date of the Triggering Event?
 mm dd yyyy
 Date Continuation Started
 mm dd yyyy
 Date Continuation Ends
 mm dd yyyy

B. If enrolling due to a qualifying life event

You may apply for coverage for yourself or a dependent outside of open enrollment due to a qualifying life event within 30 days of the date of the event (unless 60 days is required by law).

Please fill out this section unless otherwise instructed by your Group Administrator.

Adding a dependent due to:
 Marriage
 Birth, Adoption, Foster Placement, or Court Order

Enrolling and/or adding a dependent due to loss of other coverage as a result of:

- Exhaustion of COBRA Continuation
 Divorce
 Loss of dependent status
 Death
 Meeting or exceeding the lifetime benefit maximum of other plan
 Reduction in hours
 Termination of other coverage
 Termination of employment
 Termination of employer contributions toward coverage
 Offered plan is no longer in your service area
 Discontinuance of other coverage

If either of the following events occurred, you or your dependent(s) may apply within 60 days of the date of the event. Please indicate the event that applies to you and/or your dependent(s):

- Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)
 Gain eligibility for premium payment assistance from Medicaid or the Children's Health Insurance Program (CHIP)

What was the date of the Qualifying Life Event?
 mm dd yyyy

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Visit us at bcbsnc.com



**BlueCross BlueShield
of North Carolina**

C. If making a change from previous enrollment

<p>Check All That Apply:</p> <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Other Insurance Information <input type="checkbox"/> Phone Number <input type="checkbox"/> Replace ID Card <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> E-Mail Address <input type="checkbox"/> Over the Guarantee Issue <input type="checkbox"/> Other _____ _____	<p>Add Dependent(s):</p> <table border="0" style="width:100%;"> <tr> <td style="width:50%;"><input type="checkbox"/> Marriage</td> <td style="width:50%;">Date of Occurrence <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Newborn</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Court Ordered</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Adoption</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> </table> <p>Remove Dependent(s):</p> <table border="0" style="width:100%;"> <tr> <td style="width:50%;"><input type="checkbox"/> Divorce</td> <td style="width:50%;">Date of Occurrence <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Dependent Age</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Death</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> </table>	<input type="checkbox"/> Marriage	Date of Occurrence <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Newborn	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Court Ordered	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Adoption	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Other _____	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Divorce	Date of Occurrence <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Dependent Age	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Death	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Other _____	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<p>Reinstate Coverage:</p> <p>Reason: _____ _____ _____</p> <p>Cancel Coverage:</p> <table border="0" style="width:100%;"> <tr> <td style="width:50%;"><input type="checkbox"/> Not Eligible</td> <td style="width:50%;">Date of Occurrence <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td colspan="2">Reason: _____</td> </tr> <tr> <td><input type="checkbox"/> Left Employment</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Subscriber Request</td> <td><input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/></td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td colspan="2">Reason: _____</td> </tr> </table>	<input type="checkbox"/> Not Eligible	Date of Occurrence <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Reason: _____		<input type="checkbox"/> Left Employment	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Subscriber Request	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> Other		Reason: _____	
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<input type="checkbox"/> Other																																
Reason: _____																																

D. Benefits and coverage selection – complete for BCBSNC health and dental, if offered by employer

MEDICAL PLAN:	<input type="checkbox"/> Blue Options HSA SM	<input type="checkbox"/> Classic Blue [®] (CMM)	<input type="checkbox"/> Blue Select SM (PPO)	<input type="checkbox"/> No Medical Coverage
	<input type="checkbox"/> Blue Care [®] (HMO)	<input type="checkbox"/> Blue Options 1-2-3 SM	<input type="checkbox"/> Blue Local SM with Carolinas HealthCare System*	
	<input type="checkbox"/> Blue Options SM (PPO)	<input type="checkbox"/> Blue Value SM (POS)	<input type="checkbox"/> Blue Local with Duke Medicine and WakeMed**	

* I understand that I am enrolling in a plan with a local provider network limited to the Blue Local Carolinas HealthCare System network. I certify to understanding that in-network providers for this plan are concentrated in the following approved counties: Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Rowan, Stanly, and Union. I acknowledge that not all BCBSNC contracted providers may be in this plan's network, and if I visit a provider not in this plan's network, I may only receive benefits at the out-of-network level, except for emergency, urgent care, or ambulance services. I can search for a provider in the online "find a doctor" tool to determine if my provider is in my plan's network. I acknowledge that I have the right to decline my employer's coverage and enroll in different coverage outside of the coverage offered by my employer.

**I understand that I am enrolling in a plan with a local provider network limited to the Blue Local with Duke Medicine and WakeMed network. I certify to understanding that in-network providers for this plan are concentrated in the following approved counties: Caswell, Chatham, Durham, Johnston, Orange, Person, and Wake. I acknowledge that not all BCBSNC contracted providers may be in this plan's network, and if I visit a provider not in this plan's network, I may only receive benefits at the out-of-network level, except for emergency, urgent care, or ambulance services. I can search for a provider in the online "find a doctor" tool to determine if my provider is in my plan's network. I acknowledge that I have the right to decline my employer's coverage and enroll in different coverage outside of the coverage offered by my employer.

MEDICAL COVERAGE (if applicable):
 Employee Only
 Employee/Spouse/Domestic Partner
 Employee/Child(ren)
 Employee/Family

If your group is offering multiple plans, please enter plan name selected: _____

DENTAL PLAN:
 Dental
 No Dental Coverage

If your group is offering multiple plans, please enter plan name selected: _____

DENTAL COVERAGE (if applicable):
 Employee Only
 Employee/Child(ren)
 Employee/Spouse/Domestic Partner
 Employee/Family

BLUE 20/20SM VISION COVERAGE (if applicable):
 Employee Only
 Employee/Child(ren)
 Employee/Spouse/Domestic Partner
 Employee/Family

DECLINE MEDICAL COVERAGE: Check one only:
 I am rejecting Employee Coverage
 I am rejecting Dependent/Spouse Coverage

Declining coverage for the following reason (check one):

- | | |
|--|--|
| <input type="checkbox"/> Another plan offered by my employer | <input type="checkbox"/> COBRA or State Continuation |
| <input type="checkbox"/> An individual plan | <input type="checkbox"/> I and/or my dependents are not covered by any other health benefit plan |
| <input type="checkbox"/> My spouse's group coverage | <input type="checkbox"/> A government plan (type): _____ |
| <input type="checkbox"/> Other (explain): _____ | |

Names of any dependents rejecting coverage: _____

I understand that if I elect to apply for coverage for myself, my spouse/domestic partner, and/or my dependent child(ren) through this employer health plan at a later time, I may be delayed until the employer's open enrollment period.

Employee Name:

Important Notice of 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.

If your employer purchased this plan on the Small Business Health Option Program (SHOP) Exchange, you may be eligible to enroll as a result of additional triggering/qualifying events. In these cases you will have a specified timeframe within which you must enroll referred to as a special enrollment period. For a full descriptive list of triggering/qualifying events, special enrollment periods, and effective dates of coverage see www.healthcare.gov.

Signature of Primary Applicant: **X** _____ Date

Notice of Declination of Coverage must be received by Blue Cross and Blue Shield of North Carolina (BCBSNC) within 30 days of the date that employee is first eligible for coverage.

E. Family information - ONLY complete for anyone taking medical and/or dental coverage and/or Blue 20/20 coverage

Health	Dental	Blue 20/20 Vision	Name First, Middle Initial, Last, Suffix	Social Security Number (Required for Spouse/Domestic Partner)	Birthdate mm/dd/yyyy	Gender	Child Status (please check if applicable for any dependent under the age of 26)
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			<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"/> Y <input type="checkbox"/> N	Child 1			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Child 2			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Child 3*			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped

Additional Dependent form attached

* If you have more than three children enrolling on the Plan, complete an Additional Dependent form.

F. Other health insurance information

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier	Policy Number	Policy Holder Name
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Date of Birth <input type="text"/> <input type="text"/> <input type="text"/>	Effective Date <input type="text"/> <input type="text"/> <input type="text"/>	Termination Date or Expected Termination Date <input type="text"/> <input type="text"/> <input type="text"/> (If remaining active leave blank)
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What kind of coverage: Individual Group

Persons covered: Employee Spouse Domestic Partner Child1 Child2 Child3 Additional Dependents

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier	Policy Number	Policy Holder Name
-------------------	---------------	--------------------

Date of Birth <input type="text"/> <input type="text"/> <input type="text"/>	Effective Date <input type="text"/> <input type="text"/> <input type="text"/>	Termination Date or Expected Termination Date <input type="text"/> <input type="text"/> <input type="text"/> (If remaining active leave blank)
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What kind of coverage: Individual Group

Persons covered: Employee Spouse Domestic Partner Child1 Child2 Child3 Additional Dependents

If anyone covered has Medicare Coverage please complete below:			
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents			
Medicare Claim Number:		Medicare C <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Carrier's Name: _____	
Eligible Due To: <input type="checkbox"/> Renal Disease; First Day of Dialysis <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> ; Where does dialysis take place? <input type="checkbox"/> Home <input type="checkbox"/> Center;			
<input type="checkbox"/> Kidney Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Disability ; Is the member actively working? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Age			
Part A Effective Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>		Part B Effective Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	
G. Other dental insurance information			
Have you or your dependents had any other dental coverage within the last 12 months (other than BCBSNC coverage that you are applying for today)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
See important notices regarding special enrollment information attached. Please list any dental coverage the employee and/or dependents has/had within the last 12 months (including BCBSNC coverage): (To receive prior dental credit against this group benefit plan, please list prior dental coverage within the last 12 months.) BCBSNC may request a certificate of creditable coverage for verification purposes.			
Insurance Carrier		Policy Number	Policy Holder Name
Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Effective Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)	
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group			
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents			
Additional Dental Coverage that will be in-force when this policy becomes active.			
Insurance Carrier		Policy Number	Policy Holder Name
Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Effective Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)	
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group			
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents			
Additional Dental Coverage that will be in-force when this policy becomes active.			
Insurance Carrier		Policy Number	Policy Holder Name
Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Effective Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)	
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group			
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents			

H. Statement of Understanding/Legal Notices - your signature is required

I understand the benefits for which I (we) will be eligible are those described in the BCBSNC (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that BCBSNC may, within two years of the date of this application, rescind my policy for any of my 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 if I am applying for Blue Options HSA and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with BCBSNC. BCBSNC is not responsible or liable for administration of the HSA.

I understand that if I am applying for a medical plan paired with an HRA and my employer has established an HRA, the HRA may be administered by BCBSNC separately from my health insurance plan, or by a separate administrator.

Detailed information regarding my HSA/HRA will be provided by the designated 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 establishes an HSA/HRA, my employer or their designees will share certain personal information about me with these administrators to facilitate the administrator's establishment of the HSA/HRA account. By signing this application, I authorize my employer or their designees to share pertinent information with these selected 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/HRA, 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.

HSA Only:

If I am applying for Blue Options HSA, 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.

Notice of Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

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

BCBSNC Customer Service, Blue Cross and Blue Shield of North Carolina, PO Box 2291, Durham, NC 27702, 1-877-258-3334 (toll-free)

By signing below, I agree to the above Statement of Understanding and have read all of the Legal Notices.

Signature of Primary Applicant: **X**

Date

mm	dd	yyyy
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Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina (“BCBSNC”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, contact Customer Service at 1-888-206-4697; TTY and TDD, call 1-800-442-7028.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
 - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office, Telephone 919-765-1663, Fax 919-287-5613, TTY 1-888-291-1783
civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service 1-888-206-4697.



ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意: 如果您講廣東話或普通話，您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY: 1-800-442-7028)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1-800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. رقم هاتف الصم والبكم 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ: ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ: 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697 (TTY: 1-800-442-7028) まで、お電話にてご連絡ください。