NORTH CAROLINA BAR ASSOCIATION
HEALTH BENEFIT TRUST

ENROLLMENT AND CHANGE APPLICATION

☐ **Change Request:**
*For changes, complete sections **A**, **B**, and all other applicable sections*

COMPLETED BY GROUP ADMINISTRATOR ONLY
Effective Date ____________ *(mm/dd/yyyy)*
Group Number ____________

Instructions: ALL new Employees Complete **B**, **C**, **D**, **E**, **F**, **G**

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

CHECK ALL THAT APPLY:
- ☐ Name Change
- ☐ Address Change
- ☐ Telephone Change
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ Open Enrollment
- ☐ Other Insurance Information

ADD DEPENDENT(S): — DATE OF OCCURRENCE (mm/dd/yyyy):
- ☐ Marriage ____________
- ☐ Newborn ____________
- ☐ Adoption ____________
- ☐ Other ____________

☐ ELECT COBRA CONTINUATION ____________

QUALIFYING EVENT:
- ☐ Termination of Employment
- ☐ Reduction in Hours
- ☐ Divorce
- ☐ Medicare Eligible
- ☐ Social Security Disability Determination
- ☐ Overaged Dependent Now Ineligible
- ☐ Death

REINSTATE COVERAGE:
- ☐ Return from Layoff
- ☐ Return from Leave
- ☐ Retirement
- ☐ Disenrollment Error
- ☐ Other ____________
- ☐ Rehired Date: ____________

B. EMPLOYEE INFORMATION

☐ Active Employee ☐ COBRA/State Continuation: DATE CONTINUATION STARTED (mm/dd/yyyy) ____/____/____ DATE CONTINUATION ENDS (mm/dd/yyyy) ____/____/____

FIRST NAME/MIDDLE INITIAL	LAST NAME	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTHDATE (mm/dd/yyyy) ____/____/____

ADDRESS	APT. NO.	CITY	COUNTY	STATE AND ZIP

☐ MALE ☐ FEMALE	HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )	OCCUPATION

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED	FIRM NAME	WORK LOCATION	DATE OF FULL TIME EMPLOYMENT (mm/dd/yyyy) ____/____/____

C. COVERAGE SELECTION

COVERAGE: *(Check only one medical plan)* ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 10 HSA Eligible ☐ Plan 20 HSA Eligible

☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee and Family ☐ No Medical Benefits

D. FAMILY INFORMATION - Complete for anyone taking health coverage

- List family members taking health coverage.
- Handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents.

NAME *(First, Middle Initial, Last)*	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	CHILD STATUS* *(if applicable)*
SPOUSE			☐ MALE ☐ FEMALE	
CHILD 1			☐ MALE ☐ FEMALE	☐ ADOPTED ☐ FOSTER ☐ HANDICAPPED**
CHILD 2			☐ MALE ☐ FEMALE	☐ ADOPTED ☐ FOSTER ☐ HANDICAPPED**
CHILD 3***			☐ MALE ☐ FEMALE	☐ ADOPTED ☐ FOSTER ☐ HANDICAPPED**

* Consult your employer regarding dependent eligibility requirements.
** A Coverage Request for Mentally Retarded or Physically Handicapped Children (P24) form is required.
*** If you have more than three children, complete **Section D** on another application.

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION

E1. PRIOR HEALTH 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 below:***

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY

POLICYHOLDER NAME	POLICY NUMBER	POLICYHOLDER DATE OF BIRTH (mm/dd/yyyy) ____/____/____

EFFECTIVE DATE (mm/dd/yyyy) ____/____/____	TERMINATION DATE OR EXPECTED TERMINATION DATE (mm/dd/yyyy) ____/____/____	← ***If other coverage will remain in effect, write N/A in term box, and complete section below.***

FAMILY MEMBERS COVERED *(LIST NAMES AND RELATIONSHIPS)*:

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

DATES AND ID NUMBER

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 (18 months for late enrollees) 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 (or 18-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, 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.

For questions or to obtain more information, please contact Lawyers Insurance, 8000 Weston Parkway, Suite 200, Cary, NC 27513, 800-662-8843.

Application is continued on reverse side →

Employee Name ______________________

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 E2 below***

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY			
POLICYHOLDER NAME AND DATE OF BIRTH ____/____/____	POLICY HOLDER'S SOCIAL SECURITY NUMBER	If Individual Coverage Check Here ☐	
POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE			
POLICY NUMBER	EFFECTIVE DATES OF COVERAGE (mm/dd/yyyy) From: ____/____/____ To: ____/____/____		
INDIVIDUALS COVERED			
FAMILY MEMBERS COVERED BY MEDICARE			
MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO: ☐ RENAL DISEASE ☐ AGE ☐ DISABILITY	**PART A** EFFECTIVE DATE (mm/dd/yyyy) ____/____/____	**PART B** EFFECTIVE DATE (mm/dd/yyyy) ____/____/____

F. COVERAGE SELECTION Underwritten by: ■ USAble Life for Life, AD&D

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** Not available if spouse or child is also eligible for insurance under this policy as an employee

Supplemental Life / AD&D............ ☐ **Yes** ☐ **No** **Amount:** ______________

☐ **NO BENEFITS SELECTED**

F. COVERAGE SELECTION (continued)

PRIMARY BENEFICIARY NAME AND ADDRESS (REQUIRED)			
RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy) ____/____/____	SOCIAL SECURITY NUMBER	PERCENT[1]
CONTINGENT BENEFICIARY NAME AND ADDRESS (REQUIRED)			
RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy) ____/____/____	SOCIAL SECURITY NUMBER	PERCENT[1]

- I understand that if I am not actively at work as defined in the policy *(coverage listed in **Section F** of this application)* 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, 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

G. STATEMENT OF UNDERSTANDING AND AUTHORIZATION

I understand that the benefits for which I (we) will be eligible are those described in the Group Contract and/or the life insurance carrier contract and any changes provided for therein.

I understand that North Carolina Bar Association Health Benefit Trust ("Plan") 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, Plan may take legal action at any time.

HSA PLANS ONLY:

I understand that if I am applying for an HSA Eligible product offered by PLAN, the HSA is provided to me directly by a separate administrator, unaffiliated with PLAN or Blue Cross and Blue Shield of North Carolina ("BCBSNC"), and is not part of PLAN. PLAN and BCBSNC are not responsible or liable for administration of the HSA. Detailed information regarding my HSA will be provided by that administrator.

I understand that if my employer selects a BCBSNC fund administrator for my HSA, BCBSNC, my employer, PLAN or their designees will share certain personal information about me with such administrator to facilitate the administrator's establishment of the HSA account. By signing this application, I authorize BCBSNC, my employer, PLAN or their designees to share pertinent information with such administrator 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 PLAN and BCBSNC take 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 HSA Administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my High Deductible Health Plan with PLAN. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the HSA 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 Employee Signature: ______________________ Date MM / DD / YYYY