

ENROLLMENT and **CHANGE APPLICATION**

INSTRUCTIONS: ALL new employees complete B, C, D, E, F

| 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 | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| A. IF MAKING A CHAN | IGE FROM P | REVIOUS ENI | ROLLMENT | | | | | | |
|--|--|--|--|--|---|--|--|--|---|
| CHECK ALL THAT APPLY | ADD COV | /ERAGE | Date of Qualifying | Event | QU | ALIFYING | | | |
| Name Change | Marria | age | | | | Ü | Marital Sta | | Significant Cost Change in Existing Coverage |
| Address Change | | age | | | ᅦ | • | Employme Residence | | Court Orders / Judgments |
| Telephone Change | Death | 1 | | | - - | Carrier Co | verage | Affecting | Open Enrollment |
| Replace ID Card | | | | | | FMLA Elig | • | | Loss of Coverage Under Another Group Plan |
| Date of Birth Correction | Newb | oorn | | | - | | ployer Plan | - | Other Federal / State Law Allowance |
| Open Enrollment | Other | | | | | | tualifying Ev Entitlement | | Allowance |
| | | • | | | - - | | Depender | | |
| Other Insurance Information | | | | | | J | | Status for C | overage |
| B. EMPLOYEE INFORM | MATION | | | | | | 3 7 | | |
| | | JATION STARTE | D (mm/dd/yyyy) DA | TE CONTINUATION | ON EN | DS (mm/do | d/yyyy) WH | HAT WAS TH | HE DATE OF THE QUALIFYING EVENT? |
| Active Employee | | | 3333 | | | | | | |
| COBRA / State Continuation: | / | // | | /_ | _/_ | | _ | | // |
| FIRST NAME / MIDDLE INITIA | AL LAST N | IAME | | EM | PLOYE | E SOCIAL | SECURITY I | NUMBER | EMPLOYEE BIRTHDATE (mm/dd/yyyy) |
| | | | | | | | | | |
| ADDRESS | | | APT. NO. CIT | Υ | | | COUN | JTY | STATE AND ZIP |
| | | | | | | | | ••• | 577727475 Z.II |
| | | | | | | | | | |
| MALE HEIGHT | WEIGHT | HOME PHONE | NUMBER | WORK PHONE | NUMBI | ER | OCCUF | PATION | |
| FEMALE | | () | | () | | | | | |
| E-MAIL ADDRESS | | | | | | M | arital [| SINGLE | MARRIED WIDOWED |
| | | | | | | I | ATUS [| SEPARAT | TED DIVORCED |
| FIRM NAME | | | WOR | K LOCATION | | | | DATE OF F | FULL TIME EMPLOYMENT (mm/dd/yyyy) |
| | | | | | | | | | / / |
| C COVERAGE SELECT | "ION | | | | | | | _ | / |
| C. COVERAGE SELECT | | | | | - | _ | | | |
| COVERAGE (check only of | | | | | | | oyee Only | | Employee and Family |
| Plan 1 Plan 3 | ∐ Plan | 5 10 HSA Eligib | | HSA Eligible HSA Eligible | | | oyee and | • | No Medical Benefits |
| Flail 2Flail 4 | | TO HSA Eligib | nerian 15 | nsA Eligible | | Empl | oyee and | Child(ren) | |
| D. FAMILY INFORMAT | ION - Comp | olete for anyo | ne taking Health | Carraga | | | | | |
| | • | • | ne taking meanin | Coverage | | | | | |
| • List family members tak | | verage. | J | | ble de | enendent | age mavir | mum in no | alicy documents |
| List family members tak Handicapped child info | rmation requi | verage. red for all fami | ly members who e | xceed the eligi | | - | | | 1 |
| List family members tak Handicapped child info NAME (First, Middle In | rmation requi | verage. red for all fami | J | | . | ependent SEX | age maxir | mum in po | olicy documents. CHILD STATUS* (if applicable) |
| List family members tak Handicapped child info | rmation requi | verage. red for all fami | ly members who e | xceed the eligi | y) | SEX MALE | | | CHILD STATUS* |
| List family members tak Handicapped child info NAME (First, Middle In | rmation requi | verage. red for all fami | ly members who e | xceed the eligi | <u>y</u>) | SEX MALE FEMALE | | | CHILD STATUS* (if applicable) |
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| List family members tak Handicapped child info NAME (First, Middle In SPOUSE | rmation requi | verage. red for all fami | ly members who e | xceed the eligi | <u>y</u>) | SEX MALE FEMALE MALE | | | CHILD STATUS* (if applicable) |
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| effective, my insurance will no a later date, a health question • I hereby designate the above | nnaire may be required | d. ' ' | | | | se coverages I di | d not elect, | I under | rstand tha | t if I choose to e | enroll at |
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| G. COVERAGE SELECTION | | | | | | | | | | | |
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| I understand that if my e personal information ab authorize BCBSNC, my name, address, social se | out me with such ac employer, PLAN or | dministrator to facilita their designees to sh | ate the adm are pertine | ninistrator's | 's estal | blishment of th | e HSA acc | ount. I | By signin | g this applica | tion, I |
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| I understand that PLAN and BCBSNC take no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advance questions. By signing this application, I understand that I am authorizing the HSA Administrator to establish an HSA on my behalf, as of the corresponding with the effective date of my High Deductible Health Plan with PLAN. In order to activate the account, I will need to provide addiauthorization through documents that will be provided to me by the HSA Administrator. | | | | | | | | e date | | | |
| I certify that all statements | s made herein are co | omplete and true to | the best of | f my know | wledge | and my signat | ture autho | rizes a | all section | ns of this app | lication. |
| X Employee Signature: | | | | | | | | Date: | MIM | / DD / 1 | YYY |