

Employee Name _____

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.*

BCBSNC will assist in obtaining a certificate of coverage from any prior plan or issuer, if necessary.

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	POLICY NUMBER
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POLICYHOLDER NAME AND DATE OF BIRTH _____/_____/_____	EFFECTIVE DATE _____/_____/_____	TERMINATION DATE OR EXPECTED TERMINATION DATE _____/_____/_____	If other coverage will remain in effect, write N/A in term box, and complete section below.
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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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	DATES AND ID NUMBER
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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 _____/_____/_____
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POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE	If Individual coverage check here <input type="checkbox"/>	POLICY HOLDER'S SOCIAL SECURITY NUMBER
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POLICY NUMBER	EFFECTIVE DATES OF COVERAGE From: _____ To: _____
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INDIVIDUALS COVERED	FAMILY MEMBERS COVERED BY MEDICARE
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MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO: <input type="checkbox"/> RENAL DISEASE <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY	PART A EFFECTIVE DATE _____/_____/_____	PART B EFFECTIVE DATE _____/_____/_____
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F. COVERAGE SELECTION Underwritten by: Medical Life Insurance Company USAbLe Life for Life, AD&D, Disability (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 <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENT LIFE <input type="checkbox"/> YES <input type="checkbox"/> NO	WEEKLY DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	LONG TERM DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	SUPPLEMENTAL LIFE / AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO AMOUNT _____	NO BENEFITS SELECTED <input type="checkbox"/>	EMPLOYEE SALARY: _____	<input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUAL
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PRIMARY BENEFICIARY NAME AND ADDRESS (REQUIRED)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PERCENT ¹
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CONTINGENT BENEFICIARY NAME AND ADDRESS (REQUIRED)	RELATIONSHIP	DATE OF BIRTH	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 Life that I will be covered by Medical Life Insurance Company or USAbLe Life at the discretion of the employer group (as indicated above).
- 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, 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 _____

G. STATEMENT OF UNDERSTANDING AND AUTHORIZATION

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.

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 _____