

North Carolina State Health Plan

Teachers' and State Employees' Comprehensive Major Medical Plan

ENROLLMENT APPLICATION

Have you been hired within 12 months of previous State employment termination? Yes No

DECLINE COVERAGE

PLEASE TYPE OR PRINT CLEARLY • DO NOT WRITE IN SHADED AREAS

1	SOCIAL SECURITY NUMBER	EMPLOYEE LAST NAME	FIRST NAME	INITIAL
2	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed			
3	BIRTHDATE MONTH DAY YEAR	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	TELEPHONE (HOME)	TELEPHONE (WORK)
4	MAILING ADDRESS: BOX/STREET/ROUTE NUMBER CITY COUNTY STATE ZIP CODE			
5	Plan Selection <input type="checkbox"/> PPO Basic 70/30 <input type="checkbox"/> PPO Standard 80/20 <input type="checkbox"/> PPO Plus 90/10 <input type="checkbox"/> Indemnity Plan			
6	Type of Coverage Requested <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse (PPO Only) <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Family			

DEPENDENT INFORMATION → **List dependents to be included.**
Complete Certification of Dependent Eligibility Form for foster children.

	NAME <small>(FIRST, MIDDLE INITIAL, LAST)</small>	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	CHILD IS MY	COMPLETE ONLY IF CHILD IS OVER 19	MEDICARE ELIGIBLE?	DOES WAITING PERIOD APPLY?
7	SPOUSE		MONTH DAY YEAR ____/____/____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <small>(see lines 12 & 13)</small> <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8	CHILD 1		MONTH DAY YEAR ____/____/____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT <small>(see line 11)</small> <input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <small>(see lines 12 & 13)</small> <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9	CHILD 2		MONTH DAY YEAR ____/____/____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT <small>(see line 11)</small> <input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <small>(see lines 12 & 13)</small> <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
10	CHILD 3		MONTH DAY YEAR ____/____/____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT <small>(see line 11)</small> <input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <small>(see lines 12 & 13)</small> <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

11 **IF FULL-TIME STUDENT, LIST DEPENDENT'S NAME AND ACCREDITED INSTITUTION**

MEDICARE INFORMATION → List below yourself and any other persons to be covered who are eligible for Part A and/or B of Medicare.

12	NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO: <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> RENAL DISEASE	EFFECTIVE DATE ENROLLED PART A (MM/DD/YY) PART B (MM/DD/YY) ____/____/____ ____/____/____
13	NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO: <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> RENAL DISEASE	EFFECTIVE DATE ENROLLED PART A (MM/DD/YY) PART B (MM/DD/YY) ____/____/____ ____/____/____

14 **OTHER GROUP HEALTH COVERAGE** → **A BOX MUST BE SELECTED IN ORDER FOR YOUR APPLICATION TO BE PROCESSED.**
Complete the Prior Coverage/Other Coverage Information Form if you or your dependents have other group health coverage in effect, or if you or your dependents had other coverage that ended within the past 63 days. No Yes

15 COMMENTS

EMPLOYEE AUTHORIZATION

I hereby elect coverage under the plan option listed above for myself and eligible family dependents listed on the form above, and I agree that all information provided is correct. I further agree that we shall abide by the provision of the Agreement for the selected plan option.

I hereby authorize my employer to deduct from my earnings any deduction for the coverage elected above.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medically-related facility, insurance company, or other organization or institution that has any records or knowledge of the health of any covered member of my family to exchange such information with the State Health Plan.

Employee's Signature _____ Date Signed ____/____/____ Desired effective date of coverage ____/01/____

EMPLOYING UNIT MUST COMPLETE	Expedite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Waiting Period Apply? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	EMPLOYING UNIT NAME	DOES MEDICARE REDUCED RATE APPLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	GROUP NUMBER	PAYROLL NUMBER	SECTION NUMBER
	EMPLOYEE DEDUCTION \$ _____	EMPLOYER CONTRIBUTION \$ _____	HIRE DATE	EFFECTIVE DATE	PART-TIME TO FULL-TIME EMPLOYMENT DATE

SHP-C9, 1/07



Blue Cross and Blue Shield of North Carolina, the North Carolina State Health Plan and North Carolina HealthSmart are not affiliated. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.



PINK COPY should be retained by the employee and used as a temporary ID card

Submit WHITE and YELLOW COPY to employing unit

INSTRUCTIONS TO COMPLETE THE ENROLLMENT APPLICATION

- Top of Form** Health Benefits Representative checks whether the enrollee is a rehire within 12 months of termination of previous State employment.
- Line 1** Fill in your social security number and name.
- Line 2** Check the appropriate box for marital status.
- Line 3** Fill in your date of birth and check the appropriate box for sex. Print your home and work phone numbers.
- Line 4** Fill in your address.
- Line 5** Check your Plan selection.
- Line 6** Check the type of coverage desired. If you want dependent coverage, complete lines 7 through 10.
- Line 7** If you want coverage for your spouse, give his/her first name, middle initial, last name and social security number. Enter your spouse's date of birth and sex. Check "yes" or "no" to indicate whether your spouse is eligible for Medicare. If "yes" is checked, complete lines 12 or 13.

Your Health Benefits Representative will complete the waiting period information.
- Lines 8 through 10** If you want coverage for your eligible dependent child(ren), print each child's name, middle initial, last name and social security number. Enter your child's date of birth, sex and relationship to you. Complete a Certification of Dependent Eligibility Form for each foster child (available from your Health Benefits Representative) and attach it to this application.

If you have a child over 19 who is a full-time student, check "student". If you have a child over 19 who is mentally or physically incapacitated, check "handicapped" and complete a Coverage Request for Mentally or Physically Incapacitated Children (available from your Health Benefits Representative) and attach it to this application. Check "yes" or "no" to indicate whether your child is eligible for Medicare. If "yes" is checked, complete line 12 or 13.

Your Health Benefits Representative will complete the waiting period information.
- Line 11** If you checked "student" for any dependent child(ren) listed on lines 8 through 10, give the dependent's name and the name of the accredited institution that the dependent is attending.
- Lines 12 and 13** If you, your spouse or any of your children to be enrolled are eligible for Medicare, give the name, Medicare claim number, reason for Medicare eligibility, and the dates enrolled in Part A and Part B.
- Line 14** Check "yes" or "no" to indicate whether you or any of your dependents listed to be covered have other employer-sponsored group health coverage. If "yes" is checked, complete the Prior Coverage/ Other Coverage Information Form (available from your Health Benefits Representative) and attach it to this application.
- Employee Authorization** Read this statement, sign and date the form. Fill in the desired effective date of coverage. Return the form to your Health Benefits Representative. If you have questions about this form, contact your Health Benefits Representative or Customer Service at **1-888-234-2416** if you selected one of the PPO Plans; or **1-800-422-4658** if you selected the Indemnity Plan.

Your Health Benefits Representative will complete the remaining information.