NORTH CAROLINA BANKERS ASSOCIATION HEALTH BENEFIT TRUST
ADMINISTERED BY BCBSNC
CHANGE APPLICATION PLEASE TYPE OR PRINT.

☐ Medical ☐ Dental ☐ Vision

Name of Institution	Group No. BANK	Account No. 622 __ __ ___	ID Number
Employee's Name (as it appears on ID Card)			
☐ **Delete Employee – Effective Date:**			
☐ **Open Enrollment Change (Effective June 1):**			

Reason for Change
- ☐ **Legal Separation or Divorce**
- ☐ **Non-Student Status**
- ☐ **Birth**
- ☐ **Marriage**
- ☐ **Death**
- ☐ **Loss of Coverage (Attach HIPAA Cert)**
- ☐ **Subscriber Request**
- ☐ **Other**

Date of Event:

☐ **Changes to employee address/name (enter only those data elements you wish to change)**

Name	Effective Date
Address, City, Zip	Dept. Billing No.
Home Phone	Date of Birth
Marital Status	Marriage Date
	Date of Change

☐ **Change/Add/Delete Dependents** **Note: When adding dependent children below, including Alternate Recipients, number according to birth sequence.**

Check Appropriate Box	Full Name	Social Security No.	Sex	Birthdate	Relationship	If child is over age 19, please indicate status and school name
☐ Change ☐ Add ☐ Delete			☐ M ☐ F			☐ Student at _____ ☐ Handicapped
☐ Change ☐ Add ☐ Delete			☐ M ☐ F			☐ Student at _____ ☐ Handicapped
☐ Change ☐ Add ☐ Delete			☐ M ☐ F			☐ Student at _____ ☐ Handicapped
☐ Change ☐ Add ☐ Delete			☐ M ☐ F			☐ Student at _____ ☐ Handicapped

Other Health Insurance Information: On the day your coverage begins, will any family members, including those not listed above, be covered by other health insurance or Medicare? ☐ YES ☐ NO If yes, fill out this section.

Coverage type: ☐ Medical Insurance ☐ Medicare	Insurance Company and Phone Number		Policy Number
Policy Coverage Dates: _____ to _____	Name of Policyholder	Policyholder's Birthdate	Family Members Covered
Policyholder's Employer Name:		Address	Phone Number:

Names of family members covered by Medicare	Medicare Claim No.	Part A Effective Date	Part B Effective Date	Is Medicare eligibility due to: ☐ Kidney failure ☐ Handicapped ☐ Age

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give NCBAHBT – administered by BCBSNC (and any of its accrediting bodies) or any of its designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purposes of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements made by Us on this application may invalidate my and/or my dependents' coverage.

I understand this authorization shall remain valid during the15 months following the date I have signed this form as shown below.

Employee Signature: _____ **Date:** _____

Employer Signature: _____ **Date:** _____

PLEASE COMPLETE BACK OF THIS APPLICATION.

Please complete this section if you are removing yourself or any of your eligible dependents, if you are rejecting coverage for any of your newly acquired dependents, or if any dependents you are adding have had prior coverage within the 63 day period immediately preceding this change application.*

NOTE: Newly acquired or newly eligible dependents may be added to your coverage within a maximum of 30 days. Failure to enroll newly acquired or newly eligible dependents within this 30-day period will be considered rejection of coverage for the newly acquired or newly eligible dependent(s), whether or not this change form is completed.

☐ **YES** – I am rejecting Employee coverage ☐ **YES** – I am rejecting all Dependent coverage
☐ **YES** – I am rejecting coverage for my Spouse only ☐ **YES** – I am rejecting coverage for my dependent child(ren) only

I hereby certify that I have been given the opportunity to add my dependents for all insurance coverage for which they may be eligible under the Group Policy issued by North Carolina Bankers Association Health Benefit Trust. I understand the benefits available to me and to my dependents under this plan, but **I Decline** all or some of these available benefits because I and/or my dependents are covered by:

☐ Another benefit plan offered by my employer. ☐ COBRA or State Continuation.
☐ An individual plan. ☐ My spouse's group coverage.
☐ A Government plan (Type) _____. ☐ Other (Explain) _____
☐ Currently not covered by any other Group Health Benefit Plan.

Names of dependents rejecting coverage for this group plan: _____
_____

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this employer health benefit plan at a later time, the application may be subject to an extended waiting period for preexisting conditions and/or It may be delayed until the employer's open enrollment period.

Signature of Employee _____ Date _____

OTHER INSURANCE INFORMATION

Other Insured's Name and ID Number	Name and Address of Medical Insurance Carrier Providing Coverage	Employer Name	Emp/Sps/ Dep	Date Coverage Began	Date Coverage Ended	Type of Coverage Health/ Dental	COBRA Start Date	Retiree Start Date

*You may be required to provide a HIPAA Certificate of prior coverage from your dependent's former health plan administrator.