North Carolina Bankers Association Health Benefit Trust

Enrollment Form

NOTE: Please Print except for Signature

Employee Information

Employee Name (Last / First / Middle Initial)	Social Security Number	Sex	Date of Birth (MM/DD/YY)
	| | | | | | | |	M ☐ F ☐	/ /

Street Address	Home Phone Number	Marital Status	Medical Plan Election	Medical Plan Election
	( )	☐ Single	☐ PPO 100	☐ HD 1750
City		☐ Married	☐ PPO 90	☐ HD 3250
State / ZIP / County		☐ Divorced	☐ PPO 80	☐ HD 5250
		☐ Widowed	☐ PPO 70	☐ Dental
Occupation	Business Phone Number ( )	☐ Legally Separated	☐ PPO 3250	Please verify with your employer which Plans are available
			☐ PPO 4500	
			☐ PPO 1-2-3	

Dependent Coverage Elections:

Medical:	☐ Self Only	☐ Self & Spouse	☐ Self & Child(ren)	☐ Self & Family	☐ Decline Medical
Dental:	☐ Self Only	☐ Self & Spouse	☐ Self & Child(ren)	☐ Self & Family	☐ Decline Dental

** Note: If rejecting any dependent coverage, the top portion of the back of this form must be completed.*

Use this space to list all eligible dependents. Last name required if different from employee's.

Name	Date of Birth (MM/DD/YY)	Sex	Social Security Number	Relationship			Check if Handicapped	Full Time Student*
Spouse's Name Last / First / Middle Initial	/ /	☐ M ☐ F	Social Security Number (MANDATORY)					
Dependent's Name	/ /	☐ M ☐ F	Social Security Number	☐ Natural Child	☐ Step Child	Other ______	☐	☐ Yes ☐ No
Dependent's Name	/ /	☐ M ☐ F	Social Security Number	☐ Natural Child	☐ Step Child	Other ______	☐	☐ Yes ☐ No
Dependent's Name	/ /	☐ M ☐ F	Social Security Number	☐ Natural Child	☐ Step Child	Other ______	☐	☐ Yes ☐ No
Dependent's Name	/ /	☐ M ☐ F	Social Security Number	☐ Natural Child	☐ Step Child	Other ______	☐	☐ Yes ☐ No

If you or any of your covered dependents are covered by other insurance, please fill out the following information

***If Full-Time Student:**
Name of School: ____________ Address of School: ____________ Estimated Date of Graduation: ________

Other Insurance Information

Name of Person covered by other insurance		Social Security Number
Name of Company this Person works for (if applicable)	Group # / HIC #	
Name of other Insurance Company or Medicare		
Address of other Insurance Company or Medicare		

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.

Employee Signature	Date

Employer Use Only

Group #	Name of Employer		
BANK	New Hire Enrollment ____ Open Enrollment ____ Special Enrollment ____	Employment Status ☐ Full Time ☐ Part Time ☐ COBRA (Attach Election Form) ☐ Retiree	Initial
Acct. No. 622 __ ___ ___	Effective Date		
Location	☐ Hourly ☐ Salaried		
Creditable Coverage ☐ No ☐ Yes		Date of Hire:	
Pre-existing Applies ☐ No ☐ Yes Number of Months ________			

Please Complete the Back of this Application

☐ **YES** – I am rejecting Employee Coverage. ☐ **YES** – I am rejecting Dependent Spouse Coverage Only.
☐ **YES** – I am rejecting Dependent Child(ren) Coverage Only. ☐ **YES** – I am rejecting all Dependent Coverage.

I hereby certify that I have been given the opportunity to apply for all insurance coverage for which I may be eligible under the Group Policy issued by North Carolina Bankers Association Health Benefit Trust. I am NOT applying for all coverages for which I am eligible. I understand the benefits available 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.
☐ An individual plan.
☐ A Government plan (Type) ______________.
☐ I and/or my dependents are currently not covered by any other Group Health Benefit Plan.
☐ COBRA or State Continuation.
☐ My spouse's group coverage.
☐ Other (Explain) _______

**** Note: Other dependent coverage must be listed in chart below.***
Names of dependents rejecting coverage for this group plan: ____

____

OTHER INSURANCE INFORMATION

Name of Person Covered by Other Insurance	SSN	Name of Employer	Name & Address of Other Insurance Company	Group No.	Insurance ID No.

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 ______________________________

AUTHORIZATION

I AUTHORIZE any physical, medical practitioner, hospital, clinic, other medical related facility, or reinsuring company, employer, or third party administrator having information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the group policy holder, my employer, Blue Cross Blue Shield of North Carolina, or its legal representative any and all such information.

I understand that the information obtained by use of this Authorization will be used by Blue Cross Blue Shield of North Carolina to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Blue Cross Blue Shield of North Carolina to any person or organization EXCEPT to the group policy holder, my employer or as may be otherwise lawfully required or as I may further authorize.

I acknowledge that I may request a copy of this Authorization. I furthermore acknowledge that a photographic copy of this authorization shall be as valid as the original.

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

______________________________________ ______________________________________
Signature **Date**

______________________________________ ______________________________________
Dependent's Signature (over age 18 only) **Date**