Lincoln County Medical Enrollment/ Change Application

BlueCross BlueShield of North Carolina

Completed by Lincoln County Human Resources	
Hire Date:	Coverage Effective Date:

A. Employee Information

First Name | Middle Initial | Last Name | Suffix

Employee Birthdate (mm / dd / yyyy) | Employee Social Security Number | ☐ Male ☐ Female | Marital Status

Address | P.O. Box (For Blue Options HSA / HSA eligible plans you must also provide a street address.) | Apt. No. | City | State | Zip Code

Company Name: Lincoln County Government | Occupation

Work Location | Date of Full Time Employment (mm / dd / yyyy) | Language Preference ☐ Spanish ☐ English ☐ Other _____

Home Phone Number ( ) | Work Phone Number ( ) | E-Mail

Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.)

☐ African American/Black ☐ Asian/Asian American ☐ Choose not to report
☐ White/Caucasian ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Other (specify) _____

☒ Active Employee ☐ Cobra/State Continuation ☐ Retiree (51+)

COBRA/State Continuation Qualifying Life Event (QLE): ☐ Termination of Employment ☐ Reduction in Hours ☐ Death of Subscriber ☐ Divorce ☐ Over Age Dependent ☐ Medicare Eligible

What was the date of the QLE? (mm / dd / yyyy) | Date Continuation Started (mm / dd / yyyy) | Date Continuation Ends (mm / dd / yyyy)

B. Benefits and Coverage Selection – Complete for Blue Cross NC Health

MEDICAL PLAN:
☐ Blue Options HSA℠
☐ Blue Options℠ (PPO) Blue
☐ Blue Local℠ with Atrium Health*

MEDICAL COVERAGE (if applicable):
☐ Employee Only
☐ Employee/Family
☐ Employee/Child(ren)
☐ Employee/Spouse/Domestic Partner

* I understand that I am enrolling in a plan with a local provider network limited to the Blue Local with Atrium Health network. I certify to understanding that in-network providers for this plan are concentrated in the following approved counties: Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Rowan, Stanly, and Union. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network, and if I visit a provider notin this plan's network, I may only receive benefits at the out-of-network level, except for emergency, urgent care, or ambulance services.

C. Family Information – Legal Documentation May be Required

Health	Name (First, Middle Initial, Last, Suffix)	Social Security Number (Required for Spouse/Domestic Partner)	Birthdate mm/dd/yyyy	Gender	Child Status (please check if applicable)
☐ Y ☐ N	☐ Spouse ☐ Domestic Partner		mm / dd / yyyy	☐ M ☐ F	NA
☐ Y ☐ N	**Child 1**		mm / dd / yyyy	☐ M ☐ F	☐ Intellectually or physically disabled
☐ Y ☐ N	**Child 2**		mm / dd / yyyy	☐ M ☐ F	☐ Intellectually or physically disabled
☐ Y ☐ N	**Child 3**		mm / dd / yyyy	☐ M ☐ F	☐ Intellectually or physically disabled
☐ Y ☐ N	**Child 4**		mm / dd / yyyy	☐ M ☐ F	☐ Intellectually or physically disabled

D. Other Health Insurance Information

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier	Policy Number	Policy Holder Name

Date of Birth mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Additional Dependents

E. If Enrolling Due to a Qualifying Life Event

You may apply for coverage for yourself or a dependent outside of open enrollment due to a qualifying life event within 30 days of the date of the event (unless 60 days is required by law). (Legal documentation may be required.) Please fill out this section unless otherwise instructed by your Group Administrator.

Adding a dependent due to:

	Date of Occurrence		Date of Occurrence		Date of Occurrence
☐ Marriage	mm dd yyyy	☐ Adoption	mm dd yyyy	☐ Court Order	mm dd yyyy
☐ Birth	mm dd yyyy	☐ Foster Placement	mm dd yyyy	☐ Other	mm dd yyyy

Enrolling and/or adding a dependent due to loss of other coverage as a result of:

☐ Exhaustion of COBRA Continuation ☐ Divorce ☐ Loss of dependent status ☐ Death ☐ Meeting or exceeding the lifetime benefit maximum of other plan
☐ Reduction in hours ☐ Termination of other coverage ☐ Termination of employment
☐ Termination of employer contributions toward coverage ☐ Offered plan is no longer in your service area ☐ Discontinuance of other coverage

If either of the following events occurred, you or your dependent(s) may apply within 60 days of the date of the event. Please indicate the event that applies to you and/or your dependent(s):

☐ Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)
☐ Gain eligibility for premium payment assistance from Medicaid or the Children's Health Insurance Program (CHIP)

What was the date of the Qualifying Life Event? mm dd yyyy

F. If Making a Change from Previous Enrollment

Check All That Apply:

☐ Name
☐ Address
☐ Other Insurance Information
☐ Phone Number
☐ Date of Birth Correction (Legal documentation may be required.)
☐ Other _____

Remove Dependent(s): Date of Occurrence

☐ Divorce mm dd yyyy
☐ Dependent Age mm dd yyyy
☐ Death mm dd yyyy
☐ Other mm dd yyyy

Cancel Coverage: Date of Occurrence

☐ Not Eligible mm dd yyyy
Reason: _____
☐ Left Employment mm dd yyyy
☐ Other mm dd yyyy

G Declination of Health Coverage– Your Signature is Required

Sign Below ONLY IF YOU ARE DECLINING Health Coverage

DECLINE MEDICAL COVERAGE: Check one only: ☐ I am rejecting Employee Coverage ☐ I am rejecting Dependent/Spouse Coverage

Declining coverage for the following reason (check one):

☐ Another plan offered by my employer
☐ An individual plan
☐ My spouse's group coverage
☐ Other (explain): _____
☐ COBRA or State Continuation
☐ I and/or my dependents are not covered by any other health benefit plan
☐ A government plan (type): _____

Names of any dependents rejecting coverage: _____

I understand that if I elect to apply for coverage for myself, my spouse/domestic partner, and/or my dependent child(ren) through this employer health plan at a later time, I may be delayed until the employer's open enrollment period. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed. Important Notice of Special Enrollment: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance (including Medicaid or CHIP or group health plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends or if the employer stops contributing towards your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

Signature of Primary Applicant or Legal Personal Representative: _____ mm dd yyyy

H. Statement of Understanding/Legal Notices – your signature is required

I understand the benefits for which I (we) will be eligible are those described in the BCBSNC and/or the life insurance carrier (USAble Life) contract (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that BCBSNC and/or the life insurance carrier may, within two years of the date of this application, rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. If fraudulent misstatements were made, BCBSNC may take legal action at any time.I understand that if I am applying for Blue Options HSA and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with BCBSNC. BCBSNC is not responsible or liable for administration of the HSA.I understand that if I am applying for a medical plan paired with an HRA and my employer has established an HRA, the HRA may be administered by BCBSNC separately from my health insurance plan, or by a separate administrator.Detailed information regarding my HSA/HRA will be provided by the designated administrator. I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.I understand that if my employer establishes an HSA/HRA, my employer or their designees will share certain personal information about me with these administrators to facilitate the administrator's establishment of the HSA/HRA account. By signing this application, I authorize my employer or their designees to share pertinent information with these selected administrators as applicable, which may include my name, address, social security number and my employer's name. I understand that if issued a debit card in connection with my HSA/HRA, I agree that although BCBSNC's name and marks may be included on the face of the debit card for convenience, BCBSNC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card. **HSA Only:** If I am applying for Blue Options HSA, I understand that BCBSNC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my BCBSNC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator. **Notice of Women's Health and Cancer Rights Act**: If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For questions or to obtain more information, contact a BCBSNC Customer Service Representative at:

BCBSNC Customer Service, Blue Cross and Blue Shield of North Carolina, PO Box 2291, Durham, NC 27702, 1-877-258-3334 (toll-free)

By signing below, I agree to the above Statement of Understanding and have read all of the Legal Notices.

Signature of Primary Applicant: X _____ Date mm dd yyyy

I. Statement of authorization for release of protected health information – your signature is required

I understand that if I refuse to sign this authorization that BCBSNC and/or USAble Life may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC and/or USAble Life. I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

my past, present, or future physical or mental health or condition;
the provision of health care to me; or
the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy benefit manager or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to Blue Cross and Blue Shield of North Carolina ("BCBSNC") and/or USAble Life.

I further authorize BCBSNC and/or USAble Life to review any applications for health care coverage that I may have submitted to BCBSNC and/or USAble Life in the past.

I authorize BCBSNC and/or USAble Life to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:
Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that BCBSNC and/or USAble Life will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that BCBSNC and/or USAble Life will make every effort to safeguard my protected health information. I further understand that BCBSNC and/or USAble Life will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require BCBSNC and/or USAble Life to disclose my protected health information. I understand that BCBSNC and/or USAble Life may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

Tobacco Rating
Blue Cross and Blue Shield of North Carolina
P.O. Box 30013
Durham, NC 27702

USAble Life
320 West Capital Avenue
Suite 700
Little Rock, Arkansas 72201

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

(i) for information that BCBSNC and/or USAble Life already used or disclosed, relying on this authorization or

(ii) if the authorization was obtained as a condition of coverage in BCBSNC and/or USAble Life and, by law, BCBSNC and/or USAble Life has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below. After 120 days expire, BCBSNC and/or USAble Life may no longer use this information.

Signature of Primary Applicant or Legal Personal Representative: X _____ Date mm dd yyyy