



FM	DATE RECEIVED	GROUP NUMBER
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Section 1 Applicant Information

APPLICATION **MUST** BE COMPLETED IN FULL BY APPLICANT. SOCIAL SECURITY NUMBER (new applicant)
Initial and date all corrections, as we cannot accept changes made with "white out".

PRIMARY APPLICANT TO BE COVERED PLEASE PRINT IN BLUE OR BLACK INK.

LAST NAME _____ FIRST NAME _____ INITIAL _____
US POSTAL MAILING ADDRESS _____ PLEASE CHECK BOX IF THIS IS A TEMPORARY ADDRESS
CITY _____ STATE _____ ZIP _____ NC COUNTY OF RESIDENCE _____

Area Code	Evening Telephone Number
Area Code	Daytime Telephone Number

BOTH TELEPHONE NUMBERS ARE REQUIRED

BILLING ADDRESS
(if different from above - ONLY bills will be sent to this address) _____
CITY _____ COUNTY _____ STATE _____ ZIP _____
E-MAIL ADDRESS (optional) _____ REQUESTED EFFECTIVE DATE? MM _____ 1st
_____ 15th
(AT LEAST 30 BUT NO MORE THAN 60 DAYS AFTER SIGNATURE DATE)

Please fill out the following information for each person who is applying for coverage. If more space is needed, attach a separate sheet.

Name (First, Middle Initial, Last)	Marital Status	Height FT. / IN.	Weight LBS.	Social Security Number	Birthdate MONTH / DAY / YEAR	Sex	Child Status	Complete if Child is Age 19 or Over
PRIMARY APPLICANT	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced					<input type="checkbox"/> Male <input type="checkbox"/> Female		
SPOUSE	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced					<input type="checkbox"/> Male <input type="checkbox"/> Female		
CHILD 1	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced					<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"/> Full-Time Student <input type="checkbox"/> Handicapped Child
CHILD 2	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced					<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"/> Full-Time Student <input type="checkbox"/> Handicapped Child
CHILD 3	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced					<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"/> Full-Time Student <input type="checkbox"/> Handicapped Child

OCCUPATION / PROFESSION OF APPLICANT: _____ OCCUPATION / PROFESSION OF SPOUSE (if applying): _____

Section 2 Plan Coverage

DEDUCTIBLE OPTION: PLAN A \$250 \$500 \$1000 \$2500 with Maternity Coverage option (additional premium)
PLAN B \$500 \$1000 \$2500 \$5000 with Maternity Coverage option (additional premium)

APPLICANTS WHO ARE CURRENTLY PREGNANT ARE NOT ELIGIBLE FOR MATERNITY RIDER

Please review the Blue Advantage brochure provided carefully to ensure the desired Plan, deductible and maternity options are checked.

Have you also submitted a Short-Term application? Yes No

Section 3 Payment Information

BILLING FREQUENCY: MONTHLY FOR ALL APPLICANTS

BANK DRAFT OPTION (all premiums) TYPE OF ACCOUNT: CHECKING SAVINGS NAME OF BANK _____
BANK ROUTING TRANSIT NUMBER _____ This is the number accompanying your account number at the bottom of your check. NAME OF BANK ACCOUNT HOLDER _____
SIGNATURE EXACTLY AS IT APPEARS ON BANK ACCOUNT RECORDS DATE BANK ACCOUNT NUMBER A VOIDED CHECK MUST BE ATTACHED

CREDIT CARD OPTION (new enrollment, initial premium only) TYPE OF CREDIT CARD: MASTERCARD VISA CREDIT CARD NUMBER _____ EXPIRATION DATE _____
M M / Y Y

YES, I WOULD LIKE MY FIRST PREMIUM CHARGED TO MY CREDIT CARD. NAME AND ADDRESS OF CREDIT CARD ACCOUNT HOLDER _____ (PLEASE PRINT)
As a convenience to me I hereby request and authorize Blue Cross and Blue Shield of North Carolina (BCBSNC) to initiate the charge to my credit card/bank account payable to the order of BCBSNC. I agree that BCBSNC's rights in respect to each such credit card/bank draft shall be the same as if it were a check drawn on my bank account and signed by me personally. This authorization will remain in effect until I revoke it in writing at least 10 days prior to the date my account is scheduled to be debited. I agree that if such charges be dishonored, whether with or without cause and whether intentionally or inadvertently, BCBSNC shall have no liability whatsoever even though dishonor results in forfeiture of insurance. The first month's premium will be charged upon this application's acceptance. I understand my credit card/bank account will not be charged if this application is denied.
SIGNATURE EXACTLY AS IT APPEARS ON CREDIT CARD OR BANK ACCOUNT RECORDS DATE

Section 4

Questions About Your Health

All questions in this Section (Section 4) MUST be answered in their entirety. Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information.

PLEASE NOTE: "Section 5" information is required for all disorders with a "YES" answer.

Has any person applying for coverage sought medical attention and/or advice, been diagnosed with or been treated for any of the following diseases or disorders (this includes diseases or disorders past and present)?:

DISORDER	YES	NO	DISORDER	YES	NO	DISORDER	YES	NO
1. AIDS (acquired immune deficiency syndrome) or HIV (human immunodeficiency virus)	<input type="checkbox"/>	<input type="checkbox"/>	18. Migraines or headaches	<input type="checkbox"/>	<input type="checkbox"/>	29. Attention Deficit Disorder/ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>
2. Birth defect or deformity.....	<input type="checkbox"/>	<input type="checkbox"/>	Name of prescription medication: _____			Name of prescription medication: _____		
3. Were any dependents under the age of two, applying for coverage, born premature?.....	<input type="checkbox"/>	<input type="checkbox"/>	Date medication last used: _____			30. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
4. Cancer, Kaposi's Sarcoma, Melanoma, Basal Cell or Squamous Cell Carcinoma, Bowen Disease or other malignant tumor	<input type="checkbox"/>	<input type="checkbox"/>	19. Reflux (GERD), hiatal hernia, ulcers or other stomach/esophageal disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, circle type: A B C D _____		
5. Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, Parkinson's disease, Alzheimer's disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Was this 1 occurrence with full recovery?.....	<input type="checkbox"/>	<input type="checkbox"/>	Full Recovery?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Disorders of nervous system, such as brain damage, paralysis, stroke, Transient Ischemic Attack (TIA).....	<input type="checkbox"/>	<input type="checkbox"/>	Prescription medications taken: _____			Recovery date: _____		
7. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Date of last prescription use: _____			Any residual liver damage?	<input type="checkbox"/>	<input type="checkbox"/>
8. Emphysema, chronic Bronchitis or other breathing disorders	<input type="checkbox"/>	<input type="checkbox"/>	Type of surgical procedures performed (if any): _____			31. Eating disorders including Bulimia and/or Anorexia.....	<input type="checkbox"/>	<input type="checkbox"/>
Ever had breathing treatments / use of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	20. Bone, joint and muscle disorders including TMJ, bursitis, tendonitis, tennis elbow, ligament injuries/disorders, carpal tunnel disorder or rotator cuff disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	Date last treated: _____		
9. Heart attack, angina, bypass surgery or Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	Any joint replacements?	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you ever taken any prescription drugs to assist with weight loss now or in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Disorders of veins or arteries, such as Varicose veins, thrombosis, leg ulcers, peripheral vascular disease, Raynauds.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Disorders of the FEMALE reproductive system including infertility, endometriosis, recurring pelvic pain, ovarian disorder/cysts, fibroid tumors or cervical dysplasia.....	<input type="checkbox"/>	<input type="checkbox"/>	33. Alcoholism or drug dependence and/or recreational drug use.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Irregular heart rhythm or valve disorders (includes mitral valve prolapse and heart murmurs)	<input type="checkbox"/>	<input type="checkbox"/>	If cervical dysplasia only, date of last normal pap test: _____			34. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
12. Disorders of kidney, liver, pancreas, bladder or gall bladder, kidney stones or gall stones....	<input type="checkbox"/>	<input type="checkbox"/>	22. Any condition/disorder resulting in abnormal pap test (other than cervical dysplasia)?	<input type="checkbox"/>	<input type="checkbox"/>	35. Back or neck pain, chiropractic visits or disorders of the spine, discs or back	<input type="checkbox"/>	<input type="checkbox"/>
If kidney stones, date of last attack: _____			Specify condition: _____			36. Colitis, Crohn's Disease, Ileitis, Anal Fissure or Intestinal Blockage, IBS	<input type="checkbox"/>	<input type="checkbox"/>
Are stones present or on preventive medicine?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of last abnormal test: _____			37. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
If gall stones, has your gall bladder been removed?.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of last normal test: _____			insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
13. Disorders of thyroid, pituitary or adrenal gland.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Breast Implants	<input type="checkbox"/>	<input type="checkbox"/>	oral medication	<input type="checkbox"/>	<input type="checkbox"/>
14. Anemia or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	Are Breast Implants present?.....	<input type="checkbox"/>	<input type="checkbox"/>	diet controlled.....	<input type="checkbox"/>	<input type="checkbox"/>
Please indicate type of disorder (iron deficient anemia, pernicious anemia, ITP, etc) and type of treatment received.			Do you have any complications requiring the need for future replacement, treatment or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	38. Do you have any cardiac, circulatory, kidney or eye complications or amputations as a result of diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Type of anemia/ blood disorder: _____			24. Disorders of MALE reproductive systems such as impotence or prostate disorders including prostatitis or enlarged prostate gland	<input type="checkbox"/>	<input type="checkbox"/>	39. Depression, anxiety/stress, chemical imbalance, obsessive compulsive disorder, bipolar disorder or suicidal thoughts.....	<input type="checkbox"/>	<input type="checkbox"/>
Treatment received: _____			25. Sexually transmitted diseases, such as herpes, genital warts, HPV, syphilis, gonorrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	40. Eyes, ears, nose, throat disorders such as otitis media/ear infections.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Fractures with pins, plates or screws?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Disorders of the breast (males and females) including fibrocystic breast disease.....	<input type="checkbox"/>	<input type="checkbox"/>	If otitis media, number of occurrences within the last 12 months: _____		
Is hardware present?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of last normal mammogram: _____			41. High blood pressure/hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Permanent or temporary? _____			27. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	How long on current medication(s): _____		
When was hardware placed? _____			List prescription medication(s): _____			Have you had any medication change in the past 12 months due to elevated readings?	<input type="checkbox"/>	<input type="checkbox"/>
16. Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Is this medication prescribed to be used on a daily basis 12 months a year?	<input type="checkbox"/>	<input type="checkbox"/>	42. Sleep disturbances (including Sleep Apnea and Insomnia)	<input type="checkbox"/>	<input type="checkbox"/>
If yes, provide last reading: _____			Have you ever received injection therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used a CPAP machine?.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Skin disorders such as Psoriasis, Acne or Eczema.....	<input type="checkbox"/>	<input type="checkbox"/>	Date of last medication/injections: _____			Date of last use: _____		
Medications used: _____			28. Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	43. Epilepsy or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
If Psoriasis, any arthritic involvement?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last prescription medication use: _____			Date of last seizure: _____		
			Number of sinus infections within last 12 months: _____			Type of seizure: _____		
			Any previous sinus surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Is this condition controlled with medication use?	<input type="checkbox"/>	<input type="checkbox"/>
						44. Any other conditions or symptoms for which no box was provided?	<input type="checkbox"/>	<input type="checkbox"/>

Please provide details in Section 5

Questions? Please Call Blue Cross and Blue Shield of North Carolina at (800) 324-4973.

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Application is continued on the next page

DISORDER	YES	NO	DISORDER	YES	NO	DISORDER	YES	NO
45. Has anyone to be covered ever been hospitalized or had any surgical procedures for any reason OTHER than those listed below? Please do not include information already provided on other questions. Appendectomy, Hysterectomy or D&C – Non-illness related, Routine Childbirth (including C-section), Routine Colonoscopy or Sigmoidoscopy, Tonsillectomy and/or Adenoidectomy, Tubal Ligation, Vasectomy..... <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. Has any person to be covered smoked cigarettes, cigars, pipes or used chewing tobacco or snuff? ... <input type="checkbox"/> <input type="checkbox"/> Person #1 Name: _____ Date of Last Use: _____ Person #2 Name: _____ Date of Last Use: _____	<input type="checkbox"/>	<input type="checkbox"/>	48. Has any person to be covered ever been declined or had specific conditions excluded from health insurance coverage? <input type="checkbox"/> <input type="checkbox"/> If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
Please specify procedure(s) and date(s): _____ _____			47. Does any person to be covered consume alcohol? <input type="checkbox"/> <input type="checkbox"/> Person #1 Name: _____ Drinks Per Week: _____ Person #2 Name: _____ Drinks Per Week: _____	<input type="checkbox"/>	<input type="checkbox"/>	49. Has any person to be covered ever experienced any condition for which future consultation, treatment or follow-up is contemplated or advised? (please explain details in Section 5) <input type="checkbox"/> <input type="checkbox"/> List Condition: _____	<input type="checkbox"/>	<input type="checkbox"/>
						50. Has any person to be covered ever experienced any condition for which future surgery is contemplated or advised? (please explain details in Section 5) ... <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						51. Are you, your spouse, or any dependent (whether or not applying) currently pregnant or an expectant parent (male or female) <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

52. Does any person to be covered have a physical or mental impairment that substantially limits one or more major life activities: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working? Yes No

Describe each such physical or mental impairment and identify the person with such physical or mental impairment: _____

Describe how the physical or mental impairment substantially limits one or more of the major life activities stated above: _____

Is the physical or mental impairment temporary or correctable? Yes No

If yes, please explain how the physical or mental impairment is temporary or how the person plans to have it corrected: _____

Identify any other coverage providing benefits related to the stated physical or mental impairment: _____

53. Has any person to be covered taken or used prescription medications within the last 12 months, including today? Yes No **If yes, please list below:**

Person #1 Name:	Person #2 Name:	Person #3 Name:
Medication #1:	Medication #1:	Medication #1:
Condition/Reason Taking:	Condition/Reason Taking:	Condition/Reason Taking:
Indicate Frequency (daily/as needed):	Indicate Frequency (daily/as needed):	Indicate Frequency (daily/as needed):
Medication #2:	Medication #2:	Medication #2:
Condition/Reason Taking:	Condition/Reason Taking:	Condition/Reason Taking:
Indicate Frequency (daily/as needed):	Indicate Frequency (daily/as needed):	Indicate Frequency (daily/as needed):
Medication #3:	Medication #3:	Medication #3:
Condition/Reason Taking:	Condition/Reason Taking:	Condition/Reason Taking:
Indicate Frequency (daily/as needed):	Indicate Frequency (daily/as needed):	Indicate Frequency (daily/as needed):

Section 5 Explanation of Your Health

For each item checked "YES" in Section 4, please provide condition or diagnosis, treatment including medication, surgery, extent of recovery. Please put the and name and address of the appropriate physician/healthcare provider in Section 6:

Person #1 Name:	Person #2 Name:	Person #3 Name:
Actual Condition/ Diagnosis:	Actual Condition/ Diagnosis:	Actual Condition/ Diagnosis:
Date of Last or Most Recent Treatment:	Date of Last or Most Recent Treatment:	Date of Last or Most Recent Treatment:
Are You 100% Recovered From This Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are You 100% Recovered From This Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are You 100% Recovered From This Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Indicate Frequency of Condition: <input type="checkbox"/> 1 Episode Resolved <input type="checkbox"/> Reoccurs Periodically <input type="checkbox"/> Currently Being Treated	Indicate Frequency of Condition: <input type="checkbox"/> 1 Episode Resolved <input type="checkbox"/> Reoccurs Periodically <input type="checkbox"/> Currently Being Treated	Indicate Frequency of Condition: <input type="checkbox"/> 1 Episode Resolved <input type="checkbox"/> Reoccurs Periodically <input type="checkbox"/> Currently Being Treated
Number of Episodes/ Occurrences (if applicable): Indicate Number Within the Last 12 Months: _____ Indicate Number Within the Last 24 Months: _____	Number of Episodes/ Occurrences (if applicable): Indicate Number Within the Last 12 Months: _____ Indicate Number Within the Last 24 Months: _____	Number of Episodes/ Occurrences (if applicable): Indicate Number Within the Last 12 Months: _____ Indicate Number Within the Last 24 Months: _____
Details of Treatment (including name of medications/procedures):	Details of Treatment (including name of medications/procedures):	Details of Treatment (including name of medications/procedures):
Has This Condition Been Surgically Corrected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has This Condition Been Surgically Corrected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has This Condition Been Surgically Corrected? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Surgery:	Date of Surgery:	Date of Surgery:

Section 6

Your Healthcare Providers

Please list the full name, complete address including zip code, and telephone number of any health care provider(s) that has treated any person applying for coverage not already listed in Section 5. **(Please make sure that there is a name, complete address, and telephone number for at least one health care provider for each person who is applying for coverage either in this section or in Section 5.)** If more space is needed, attach a separate sheet, with your signature and the date.

Applicant's First Name	Full Name, Complete Address Including Zip Code, and Telephone Number of Healthcare Provider

Section 7

Other Healthcare Coverage

	YES	NO		YES	NO		YES	NO
1. Is anyone applying covered by Medicare benefits Part A and/or Part B?	<input type="checkbox"/>	<input type="checkbox"/>	2. Has anyone to be covered, applied for or been accepted for Social Security disability or private disability insurance?.....	<input type="checkbox"/>	<input type="checkbox"/>	5. If yes to Question 4 , will you cancel your other insurance coverage if you are approved for this coverage? (You must cancel your other coverage if you accept this coverage).....	<input type="checkbox"/>	<input type="checkbox"/>
If yes , give name(s):	_____		3. Has anyone to be covered received a permanent disability rating with workers' compensation?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you ever had Blue Cross and Blue Shield of North Carolina insurance?	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____		4. Is any person applying for coverage currently covered by another health insurance program?	<input type="checkbox"/>	<input type="checkbox"/>	7. Is any person applying for coverage currently covered by Blue Advantage?	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____							

Please list all coverage for you or your dependents within the last 18 months. As verification of this section, you must attach a certification or some other proof of your most recent policy that **must include effective and termination dates to receive portability credit.**

NAME OF PERSON APPLYING FOR COVERAGE	NAME, ADDRESS AND PHONE NUMBER OF PREVIOUS CARRIER	POLICYHOLDER, SPOUSE OR DEPENDENT?	POLICYHOLDER'S ID NUMBER	EFFECTIVE DATE			TERMINATION DATE			EMPLOYER GROUP PLAN OR INDIVIDUAL PLAN?
				MONTH	DAY	YEAR	MONTH	DAY	YEAR	

If more space is needed, please attach a separate sheet.

Section 8

Statement of Understanding

I understand that by signing this Statement of Understanding, I am agreeing to the following conditions:

- I certify that all statements on this application are complete and true. **I understand that for a period of two years from the date coverage is issued, Blue Cross and Blue Shield of North Carolina (BCBSNC) may void or terminate my certificate of 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 understand that the coverage applied for will be issued if the following conditions are met: i) BCBSNC must receive a completed application and any medical records or other information requested, ii) BCBSNC finds that I am eligible for this coverage as of the date of the application. Benefits will not be available until the entire premium has been applied to my policy. BCBSNC will issue me a health care benefits booklet and identification card for coverage. The deposit of premium fees by BCBSNC does not indicate an acceptance of this application.
- I understand that I will not be declined for health conditions, although rates upon issue may be higher than the original quoted rates. I understand that any coverage provided according to this application will be subject to the provisions of the benefit booklet, which is issued to me by BCBSNC.
- I understand that coverage is not provided for a pre-existing condition within the first 12 months after my effective date, unless I receive credit toward some or all of this waiting period. This means that during this waiting period I will not receive benefits for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 12 months prior to my effective date. The waiting period for pre-existing conditions will be reduced by the amount of time spent on prior creditable coverage if terminated no more than 63 days prior to the application receipt date under this health benefit plan.
- I understand that final rates cannot be determined until my application is processed and completed. I understand that once my application is approved I have 10 days to review my benefit booklet and ID card. If I'm not completely satisfied, I will notify BCBSNC within the 10-day period to terminate coverage.

As the primary applicant, I warrant that I am authorized to agree to the above statements on behalf of all of my dependents, including those dependents who have not signed below.

X	_____	_____	X	_____	_____
	SIGNATURE OF PRIMARY APPLICANT OR SIGNATURE OF PARENT/GUARDIAN (IF APPLICANT UNDER AGE 18)	DATE		SIGNATURE OF APPLICANT SPOUSE	DATE
X	_____	_____	X	_____	_____
	SIGNATURE OF APPLICANT DEPENDENT AGE 18 AND OLDER	DATE		SIGNATURE OF APPLICANT DEPENDENT AGE 18 AND OLDER	DATE

An additional sheet should be added for additional adult dependent.

A copy of this authorization shall be as valid as the original.

Questions? Please Call Blue Cross and Blue Shield of North Carolina at (800) 324-4973.

An Independent Licensee of the Blue Cross and Blue Shield Association.

Application is continued on the reverse side

Authorization for Release of Protected Health Information

I understand that if I refuse to sign this authorization that BCBSNC may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC.

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:

- (i) my past, present, or future physical or mental health or condition;
- (ii) the provision of health care to me; or
- (iii) 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 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").

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

I authorize BCBSNC 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 will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that if my protected health information is to be 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:

**Individual Business Operations
Blue Cross and Blue Shield of North Carolina
PO Box 30016 • Durham, NC 27702-3016**

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 already used or disclosed, relying on this authorization or
- (ii) if the authorization was obtained as a condition of coverage in BCBSNC and, by law, BCBSNC has a right to contest the coverage.

This authorization expires 30 months from the date this authorization is signed by the applicant or personal representative.

X _____ **X** _____
SIGNATURE OF PRIMARY APPLICANT OR PERSONAL REPRESENTATIVE DATE SIGNATURE OF APPLICANT SPOUSE DATE

X _____ **X** _____
SIGNATURE OF APPLICANT DEPENDENT AGE 18 OR OLDER DATE SIGNATURE OF APPLICANT DEPENDENT AGE 18 OR OLDER DATE

NAME OF LEGAL PERSONAL REPRESENTATIVE (PLEASE PRINT) DESCRIPTION OF LEGAL PERSONAL REPRESENTATIVE'S AUTHORITY

APPLICANT'S SOCIAL SECURITY NUMBER

Blue Cross and Blue Shield of North Carolina will provide a signed copy of this form.

This page is part of the application.

REV. 08/04

Questions? Please Call Blue Cross and Blue Shield of North Carolina at (800) 324-4973.

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BlueCross BlueShield of North Carolina

Helpful hints to speed the process of your application

Please read carefully. It is important to complete your application correctly in order for us to process your application for enrollment. Any errors or omissions will cause a delay in your coverage.

- **All Sections must be completed.**
- **Applications must be completed with a blue or black ink pen.**
- **We cannot accept changes made with “white out”. Initial and date any corrections.**

The most missed items on the application:

- **Section 1:** Please include yourself and all family members that need to be covered. Please make sure to include height, weight, birth date, and social security number. We must have both daytime and evening phone numbers.
- **Section 3:** Please sign Section 3 if you are using the bank draft or credit card option for payment.
- **Section 4:** It is imperative that ALL 53 questions in this Section be checked “YES” or “NO”.
- **Section 8:** The primary applicant must sign their name in this Section. A spouse or any dependents ages 18 and over applying for coverage must sign the application also. Please date each signature as well. Please sign the Authorization for Release of Protected Health Information Section.
- **Section 9:** Please only sign this Section if you would like to decline coverage for all applicants in the case that any other applicant on this application be declined for coverage by BCBSNC.

When you have completed the required information, you can fax or mail your application to the address or fax number listed below:

Fax: 919-765-4807

Mail: Blue Cross and Blue Shield of North Carolina
PO Box 30016
Durham, NC 27702-3016

For answers to additional questions, call a Blue Cross and Blue Shield of North Carolina Product Specialist at (800) 324-4973.

Once a final decision is made regarding your application, you will be notified of our decision.