

Enrollment/Change Application

Instructions:

- All employees complete Sections **A, C, D, E, G** and **H**.
- For change requests, complete Sections **A, B** and all other applicable sections.
- If your group has elected USABLE Life products you must complete Section **F**.
For USABLE^{®1} Life Only you must complete Sections **A, B, F, G** and **H**.

Completed by Group Administrator Only
Group Number (if applicable):
Life Class Designation (if applicable):

Please type or print in black or blue, NOT RED ink

A. Employee information

First Name	Middle Initial	Last Name	Suffix
Employee Birthdate mm dd yyyy	Employee Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status
Address	P.O. Box <i>(For Blue Options HSA you must also provide a street address.)</i>	Apt. No.	City State Zip Code
Company Name ACI SUPPORT SPECIALISTS, INC.	Occupation		
Work Location	Date of Full Time Employment mm dd yyyy	Language Preference <input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other _____	
Home Phone Number ()	Work Phone Number ()	E-Mail Address	

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 Native American/Alaskan Native Other (specify) _____

ACTIVE EMPLOYEE COBRA/STATE CONTINUATION

COBRA/State Continuation Qualifying Event:

Termination of Employment Reduction in Hours Death of Subscriber Divorce Over Age Dependent Medicare Eligible

What was the date of the Qualifying Event? mm dd yyyy Date Continuation Started mm dd yyyy Date Continuation Ends mm dd yyyy

B. If making a change from previous enrollment

Check All That Apply: <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Other Insurance Information <input type="checkbox"/> Telephone <input type="checkbox"/> Replace ID Card <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> E-Mail Address <input type="checkbox"/> Late Applicant <input type="checkbox"/> Over the Guarantee Issue <input type="checkbox"/> Other _____	Add Dependent(s): <input type="checkbox"/> Marriage Date of Occurrence mm dd yyyy <input type="checkbox"/> Newborn Date of Occurrence mm dd yyyy <input type="checkbox"/> Adoption Date of Occurrence mm dd yyyy <input type="checkbox"/> Other _____ Date of Occurrence mm dd yyyy	Reinstate Coverage: Reason: _____ _____ _____
	Remove Dependent(s): <input type="checkbox"/> Divorce Date of Occurrence mm dd yyyy <input type="checkbox"/> Dependent Age Date of Occurrence mm dd yyyy <input type="checkbox"/> Death Date of Occurrence mm dd yyyy <input type="checkbox"/> Other _____ Date of Occurrence mm dd yyyy	Cancel Coverage: <input type="checkbox"/> Not Eligible Date of Occurrence mm dd yyyy Reason: _____ <input type="checkbox"/> Left Employment Date of Occurrence mm dd yyyy <input type="checkbox"/> Subscriber Request Date of Occurrence mm dd yyyy <input type="checkbox"/> Other Reason: _____

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Employee Name:

C. Benefits and coverage selection – complete for BCBSNC health and dental, if offered by employer

MEDICAL PLAN: No Medical Coverage ~~Blue Options HSASM~~ Blue Options PPO ~~Blue Options 1-2-3~~ ~~High~~
 ~~Blue Care[®] (HMO)~~ ~~Classic Blue[®] (CMM)~~ ~~Blue Options HRASM~~ ~~Low~~

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

DENTAL PLAN: No Dental Coverage Dental

DENTAL COVERAGE (if applicable): Employee Only Employee/Child(ren) Employee/Spouse Employee/Family

D. Family information – complete for anyone taking medical and/or dental coverage*

NAME First, Middle Initial, Last, Suffix	Social Security Number	Birthdate mm/dd/yyyy	Sex	H E A L T H	D E N T A L	Child Status (please check one)
Spouse	required		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***
Child 3****			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***

* Application does not guarantee enrollment.
 ** A request for coverage (form P24) is required if your child is 26 years or older and will be reviewed to determine eligibility.
 *** Consult your employer regarding dependent eligibility requirements. Supporting documentation may be required.
 **** If you have more than three children, complete **Section D** on another application.

Additional dependent and/or custodial parent information attached.

E. Other health/dental insurance information

Have you or your dependents had any other health or dental coverage within the last 12 months (other than BCBSNC coverage that you are applying for today)? Yes No

See important notices regarding pre-existing condition limitations and special enrollment information attached.

Please list any health or dental coverage the employee and/or dependents has/had within the last 12 months (including BCBSNC coverage):

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 Medical Dental (Proof of dental coverage must be included with application for processing)

Persons covered: Employee Spouse Domestic Partner Child1 Child2 Child3 Additional Dependents

Additional 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 Medical Dental (Proof of dental coverage must be included with application for processing)

Persons covered: Employee Spouse Domestic Partner Child1 Child2 Child3 Additional Dependents

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

Insurance Carrier _____ Policy Number _____

Policy Holder Name _____ Date of Birth mm dd yyyy

Employee Name:

Effective Date	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	Termination Date or Expected Termination Date	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	(If remaining active leave blank)
What kind of coverage:	<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	(Proof of dental coverage must be included with application for processing)			
Persons covered:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child1	<input type="checkbox"/> Child2	<input type="checkbox"/> Child3	<input type="checkbox"/> Additional Dependents	

If anyone covered has Medicare Coverage please complete below:

Persons covered:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Child1	<input type="checkbox"/> Child2	<input type="checkbox"/> Child3	<input type="checkbox"/> Additional Dependents				
Medicare Claim Number:				Eligible Due To:	<input type="checkbox"/> Renal Disease	First Day of Dialysis	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	<input type="checkbox"/> Disability	<input type="checkbox"/> Age
Part A Effective Date:	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	Part B Effective Date:	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>				

F. Coverage selection for products underwritten by USABLE Life, if offered by employer

USABLE Life is an independent life insurance company that does not provide BCBSNC products or services. USABLE Life is solely responsible for the life and disability insurance coverage below. Your non-medical group insurance program may not include all the benefits listed below. These benefits will be written by USABLE Life. Ask your employer details. Employer is required to retain a copy of this form for beneficiary information.

Life/AD&D	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> No Benefits Selected
Dependent Life	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Weekly Disability	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Long Term Disability	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Supplemental Life/AD&D	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Applying For Over Guarantee Issue
Supplemental Life/AD&D Amount:			N/A

Employee's Annual Salary (Required If Salary Based Plan)	Employee's Job Title
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Primary Beneficiary Name (required)	Primary Beneficiary Address (required)
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Relationship	Date of Birth	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	Social Security Number	Percent ¹
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Second Primary Beneficiary Name (required)	Second Primary Beneficiary Address (required)
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Relationship	Date of Birth	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	Social Security Number	Percent ¹
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Contingent Beneficiary Name (required)	Contingent Beneficiary Address (required)
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Relationship	Date of Birth	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	Social Security Number	Percent ¹
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Second Contingent Beneficiary Name (required)	Second Contingent Beneficiary Address (required)
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Relationship	Date of Birth	<input type="text" value="mm"/>	<input type="text" value="dd"/>	<input type="text" value="yyyy"/>	Social Security Number	Percent ¹
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¹ NOTE: The primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I select any of the products listed above that I will be covered by USABLE Life at the discretion of the employer group (as indicated above).
- I understand that if I am not actively at work as defined in the policy(ies) (for the products selected above) on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

SIGN HERE →
 X Signature: _____ Date

Life insurability questionnaire - complete only if you are a late applicant or applying for coverage over the guarantee issue amount

1. Employee Height:	2. Employee Weight:
3. Have you used any tobacco products in the past year?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you have any condition for which consultation or treatment is contemplated or has been advised?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you been hospitalized for any reason during the past five (5) years?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you consulted a physician in the past one (1) year for any reason?	<input type="checkbox"/> <input type="checkbox"/>

Employee Name:

7. Have you ever been diagnosed or treated by a member of the medical profession for:

	Yes	No		Yes	No
a. Cancer, cancer related disease or benign tumor?	<input type="checkbox"/>	<input type="checkbox"/>	f. Emotional, nervous system, eating disorder, or mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>
b. Disease of the heart or blood vessels, or had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	g. Ulcer, stomach or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c. Kidney disease or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Arthritis, back, bones or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	i. Bladder, urinary system or reproductive organs disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Lung, asthma, liver or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>			

8. Have you ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")? Yes No

9. Have you ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? If yes, list name of person(s), medications taken, medication dosage, and last two blood pressure readings. Yes No

10. Are you currently taking medication(s)? If yes, list name of person, medications and dosage. Yes No

11. Have you ever had any impairments, diseases or illnesses not covered in questions 2-8? Yes No

12a. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	12b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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13. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If no, give full details. Yes No

14. Names, addresses, and phone numbers of the personal physicians of all applicants:

G. Statement of understanding - your signature is required

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina (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 Blue Cross and Blue Shield of North Carolina (BCBSNC). BCBSNC is not responsible or liable for administration of the HSA.

I understand that if I am applying for Blue Options 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.

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.

SIGN HERE →

X Signature: _____ Date

