NC MS

North Carolina Medical Society
Employee Benefit Plan

ENROLLMENT APPLICATION AND CHANGE FORM

Please Use Ink When Completing

☐ ENROLLMENT FORM - Complete Sections A, C, D, E, and all other applicable sections.

☐ CHANGE FORM - Complete Section A, B, and all other applicable sections.

COMPLETED BY GROUP ADMINISTRATOR ONLY	
GROUP NUMBER	
DEPT/DIV NUMBER	EFFECTIVE DATE

A. EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	MARITAL STATUS	SEX

DATE OF BIRTH	ADDRESS	CITY	STATE	ZIP CODE	COUNTY	HOME PHONE

DATE OF FULL-TIME EMPLOYMENT	EMPLOYER NAME AND ADDRESS	WORK LOCATION	OCCUPATION	WORK PHONE

B. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

CHECK ALL THAT APPLY:
- ☐ Name
- ☐ Address
- ☐ Telephone
- ☐ Date of Birth Correction
- ☐ Replace ID Card
- ☐ Open Enrollment
- ☐ Late Applicant
- ☐ Other Insurance Information

ADD DEPENDENT(S): DATE OF OCCURENCE
- ☐ Marriage _____
- ☐ Newborn _____
- ☐ Adoption _____
- ☐ Other_____ _____

REMOVE DEPENDENT(S): DATE OF OCCURENCE
- ☐ Marriage _____
- ☐ Divorce _____
- ☐ Dependent Age _____
- ☐ Death _____
- ☐ Other_____ _____

CANCEL COVERAGE: DATE OF OCCURENCE
- ☐ Not Eligible _____
- ☐ Left Employment _____
- ☐ Subscriber Request _____
- ☐ Other_____ _____

CONTINUE COVERAGE:
- ☐ State Continuation (groups under 20 employees)
- ☐ COBRA (groups with 20 or more employees)

Continuation Effective Date_____

CONTINUATION REASON:
- ☐ Death of Subscriber
- ☐ Medicare Eligible
- ☐ Reduction in Hours
- ☐ Divorce
- ☐ Termination of Employment
- ☐ Over Age Dependent

C. COVERAGE ELECTION

MEDICAL PLAN *(check one)*

PPO	☐1000-70 ☐1500-70 ☐2000-80 ☐2000-70 ☐2500-80 ☐2500-70 ☐3500-80 ☐3500-70 ☐5000-60 ☐2500-60 ☐3500-60	FOR INTERNAL USE ONLY
PPO VALUE	☐2000-70 ☐2500-70 ☐3500-70 ☐2500-60 ☐3500-60	**PPO ESSENTIAL** ☐7900-100
PPO 1-2-3	☐1500 ☐2000 ☐2500 ☐3500 ☐4000 ☐5000 ☐5000 (alternate Rx)	PACKAGE NUMBER
HDHP	☐2700-80 ☐2700-100 ☐3500-100 ☐5000-100 ☐6350-100 ☐5500-70 ☐7000-100	**HDHP VALUE** ☐2700-100 ☐3500-100

COVERAGE TYPE (check one)
☐Employee Only ☐Employee/Spouse/Domestic Partner ☐Employee/Child ☐Employee/Children ☐Employee/Family

CLASS TYPE (must indicate one) ☐Physician ☐Non-Physician

DECLINE COVERAGE (check one)
☐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 ☐COBRA or State Continuation ☐An individual plan ☐My spouse's group coverage

☐I and/or my dependents are not covered by any other health benefit plan ☐A government plan (type):_____

☐Other (explain): _____

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.

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 Children's Health Insurance Program (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 you or your dependents' other coverage ends (other than Medicaid or CHIP) 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.

In addition, 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.

SIGN BELOW ONLY IF DECLINING HEALTH COVERAGE.

Signature of Declining Employee: X_____ **Date:**_____

Marketed exclusively by Curi Benefits Solutions

Employee Name:_____

D. FAMILY INFORMATION (ONLY complete for anyone taking medical coverage)

NAME (First, Middle Initial, Last)	SOCIAL SECURITY NUMBER (Required for Spouse/DP Only)	BIRTHDATE mm/dd/yyyy	GENDER	CHILD STATUS (if applicable)
☐SPOUSE ☐DOMESTIC PARTNER				
CHILD #1				☐Foster ☐Adopted ☐Handicapped
CHILD #2				☐Foster ☐Adopted ☐Handicapped
CHILD #3 (If you have more than three children, complete Section D on another application)				☐Foster ☐Adopted ☐Handicapped

E. COORDINATION WITH OTHER INSURANCE COMPANIES (If you have more than one additional policy in force, complete Section E of another application)

This section **MUST** be completed if you have additional insurance in force.
Are any dependents covered under another plan due to divorce/separation? ☐Yes ☐No
Will you or your covered dependents have other insurance in addition to this policy? ☐Yes ☐No
IF YES TO EITHER QUESTION, complete below:

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY	POLICYHOLDER NAME AND DATE OF BIRTH
POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE	POLICYHOLDER SOCIAL SECURITY NUMBER
POLICY NUMBER	EFFECTIVE DATES OF COVERAGE FROM: _____ TO:_____
INDIVIDUALS COVERED	FAMILY MEMBERS COVERED BY MEDICARE

MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO: ☐Renal Disease ☐Age ☐Disability	MEDICARE **PART A** EFFECTIVE DATE	MEDICARE **PART B** EFFECTIVE DATE

F. BENEFICIARY DESIGNATION/CHANGE (If your employer offers Term Life and AD&D Insurance) ☐ Check if New Employee ☐ Check if Change Only

This will revoke and replace any exisiting beneficiary designations you may have for these benefits.

PRIMARY BENEFICIARY(IES)
(Will receive proceeds if living at death of Employee)

NAME (First, Middle Initial, Last)	ADDRESS	BIRTHDATE (mm/dd/yyyy)	RELATIONSHIP	PERCENTAGE

TOTAL MUST EQUAL 100% =

CONTINGENT BENEFICIARY(IES)
(Will receive proceeds if primary beneficiary[ies] are not living)

NAME (First, Middle Initial, Last)	ADDRESS	BIRTHDATE (mm/dd/yyyy)	RELATIONSHIP	PERCENTAGE

TOTAL MUST EQUAL 100% =

G. DEPENDENT LIFE INSURANCE (If your employer offers Dependent Life Insurance)

Dependent Life Coverage Election: ☐ Accept ☐ Decline

Employee Name:_____

H. UNDERWRITING QUESTIONS FOR ALL APPLICANTS

Please provide the answers to the following questions as they pertain to any person, employee or dependent, applying for coverage.

Condition	Yes	No	Condition	Yes	No
Accidental Injury			High Risk Pregnancy		
AIDS/HIV Disease			Intestinal Malabsorption		
Alcohol or Drug Dependency or Abuse			Liver Disease		
Alpha 1 (Antitrypsin Deficiency)			Mental Disorder/Depression		
Amyloidosis			Morbid Obesity		
Anterior Horn Cell Disease			Mucopolysaccharidoses (Morquio syndrome)		
Back Disorders			Multiple Sclerosis		
Blood Disorder (Hemophilia, sickle cell, etc.)			Muscular Dystrophy		
Bronchial or Pulmonary Candidiasis			Nervous System Disorder		
Burns - Severe			Osteomyelitis		
Cancer, Leukemia, Lymphoma, Neoplasms, etc.			Pancreatitis		
Cardiomyopathy			Renal Disease		
Cerebral Vascular Disease/Stroke			Respiratory Problem		
Chronic Inflammatory Demylinating Polyneuropathy			Seizures		
Cystic Fibrosis			Septicemia		
Diabetes or High Blood Sugar			Traumatic Injury - Major (Spinal cord, head, etc.)		
Gaucher's Disease			Toxoplasmosis		
Heart/Lung Disease			Tuberculosis		
Hepatitis			Other_____		
High Blood Pressure			Other_____		

Indicate if any person, eligible employee or dependent, applying for coverage,

Is currently pregnant? ☐Yes ☐No
Is scheduled for hospitalization and/or surgery? ☐Yes ☐No
Has undergone treatment for any mental or physical illness during the past two years which resulted in expenses in excess of $10,000? ☐Yes ☐No
Had had a serious job related injury in the past two years? ☐Yes ☐No
Is a potential transplant recipient? ☐Yes ☐No
Has had or is considering gastric bypass? ☐Yes ☐No
Has an implant of a heart assist device? ☐Yes ☐No

For any applicant, provide all conditions or diagnosis, treatment, medication, surgery, for all medical conditions ongoing or where treatment occurred in last three (3) years. Also include information for any YES answers above. If more space is needed, submit a separate sheet with your signature and date. Please print clearly and legibly.

	DIAGNOSIS	TREATMENT AND MEDICATIONS	LAST DATE TREATED
Applicant #1			
Applicant #2			
Applicant #3			
Applicant #4			
Applicant #5			
Applicant #6			

Employee Name:_____

I. STATEMENT OF UNDERSTANDING, LEGAL NOTICES, AND AUTHORIZATION (Signature Required)

I understand that the benefits for which I (we) will be eligible are those described in the group contract (including the benefit booklet) and any 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 the NORTH CAROLINA MEDICAL SOCIETY EMPLOYEE BENEFIT PLAN ("PLAN") 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, the PLAN may take legal action at any time.

I understand that if I am applying for a HDHP product and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with the PLAN. The PLAN 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, or by a separate administrator. Detailed information regarding by HSA/HRA will be provided by the designated administrator. 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 nor the PLAN are 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: BCBSNC nor the PLAN take 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 coverage with my employer.

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: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses and; 4) 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 the plan. For questions or to obtain more information, contact: North Carolina Medical Society Employee Benefit Plan, Attention: Customer Service, P.O. Box 97968, Raleigh, NC 27624,1-800-662-7917 (toll free).

Statement of authorization for release of protected health information
I understand that if I refuse to sign this authorization that the PLAN and/or USAble Life may refuse to enroll me or determine that I am not eligible for benefits in the PLAN 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: (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, 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"), the PLAN, and/or USAble Life. I further authorize the PLAN and/or USAble Life to review any applications for health care coverage that I may have submitted to the PLAN and/or USAble Life in the past.

I authorize the PLAN, 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 the PLAN, BCBSNC and/or USAble Life will use my protected health information to determine my eligibility for enrollment and my premium rate. I understand that the PLAN, BCBSNC and/or USAble Life will make every effort to safeguard my protected health information. I further understand that the PLAN, 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 the PLAN, BCBSNC and/or USAble Life to disclose my protected health information. I understand that the PLAN, 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, AR 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 the PLAN, 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 the PLAN and/or USAble Life and, by law, the PLAN 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, the PLAN, BCBSNC and/or USAble Life may no longer use this information.

Signature of Employee: X_____ **Date:**_____