

New Enrollment

Date Received by BCBSNC

Application must be completed in full by applicant(s).

Section 1: New Enrollment Request

- Please specify an effective date at least 30 days, but no more than 60 days, after the signature date on this application.

Effective date: 1st or 15th

Please complete, sign and date the application- Fax or email back to us:

1-877-298-0150 or dpartridge@mycapbenefits.com

- Complete all sections of this application.

Section 2: Applicant Information

Please fill in all information for each person who is applying for coverage.

Name (First, Middle Initial, Last)	Marital Status	Social Security Number	Birthdate Month Day Year	Sex	Height ft. / in.	Weight lbs.
Primary Applicant	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated	- -	MM / DD / YY	M F <input type="checkbox"/> <input type="checkbox"/>		
Spouse Applicant	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated	- -	MM / DD / YY	M F <input type="checkbox"/> <input type="checkbox"/>		

To enroll one child only, you may list that child as the Primary Applicant above. Please note: Children under age 18 are not eligible for a Health Savings Account unless applying as a dependent under their parent's health policy.

Dependent Children Under 26 or Handicapped (First, Middle Initial, Last)	Child Status	Social Security Number	Birthdate Month Day Year	Sex	Height ft. / in.	Weight lbs.
Dependent Child 1	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Foster	- -	MM / DD / YY	M F <input type="checkbox"/> <input type="checkbox"/>		
Dependent Child 2	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Foster	- -	MM / DD / YY	M F <input type="checkbox"/> <input type="checkbox"/>		
Dependent Child 3	<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Foster	- -	MM / DD / YY	M F <input type="checkbox"/> <input type="checkbox"/>		

This application is designed to accommodate up to 3 dependent children. For options on how to apply for coverage with 4 or more dependent children, call your local agent.

Section 3: Primary Applicant's Contact Information

Required telephone numbers (where you can best be reached)

Evening number with area code: _____ Daytime number with area code: _____

Primary applicant's U.S. mailing address (Please check box if this is a temporary address)

Street or P.O. Box: _____ Apt. or suite: _____

City and State: _____ Zip code: _____

NC county of residence: _____ Email address: _____

Primary applicant's billing address (if different from mailing address—ONLY bills will be sent to this address)

Street or P.O. Box: _____ Apt. or suite: _____

City and State: _____ Zip code: _____

Section 4: Plan Coverage Selection

I am applying for **BlueAdvantage** coverage.

In the grid below, check the box that matches both the coinsurance and the deductible that you want (please check only one box).

		In-Network Deductible			
		\$1,000	\$2,500	\$3,500	\$5,000
Coinsurance	Plan A 80%				
	Plan B 70%				
	Plan C 50%				

Maternity Rider Option
(additional premium)

Yes No

Applicants who are currently pregnant are NOT eligible for the maternity rider option unless their most recent creditable coverage was underwritten by BCBSNC and included maternity coverage.

Dependent children also are NOT eligible for maternity rider option.

I am applying for **BlueOptionsHSA** coverage.

In the grid below, check the box that matches both the coinsurance and the deductible that you want (please check only one box).

INDIVIDUAL PLANS (Covering 1 person)

		In-Network Deductible	
		\$2,700	\$5,000
Coinsurance	100%		
	80%		
	50%		

FAMILY PLANS (Covering more than 1 person)

		In-Network Deductible	
		\$5,450	\$10,000
Coinsurance	100%		
	80%		
	50%		

Maternity Rider Option
(additional premium)

Yes No

Applicants who are currently pregnant are NOT eligible for the maternity rider option unless their most recent creditable coverage was underwritten by BCBSNC and included maternity coverage.

Dependent children also are NOT eligible for maternity rider option.

Section 5: Payment Information

Authorization for Bank Draft and/or Credit Card Charge

By signing below, I certify that I am an authorized user of this bank account and/or credit card. I understand that the bank account/credit card listed cannot be my employer's account.

If I have chosen the Bank Draft Option, as a convenience to me, I hereby request and authorize BCBSNC to initiate the debit to my bank account payable to the order of BCBSNC for my first and subsequent months' premiums. I understand that BCBSNC may attempt to debit my bank account up to three times for each month's premium to ensure no lapse in coverage. BCBSNC does not charge a fee for this service; however, I am aware that my bank may charge a fee if there are insufficient funds to cover the payment. I agree that BCBSNC's rights with respect to the bank draft shall be the same as if it were a check drawn on my bank account and signed by me personally. I also authorize my financial institution to reduce the balance of my bank account by the amount of each monthly draft.

If I have chosen the Credit Card and Direct Billing Option, as a convenience to me, I hereby request and authorize Blue Cross and Blue Shield of North Carolina (BCBSNC) to charge my credit card for my first payment. I also authorize my financial institution to charge my credit card account for the credit card charge.

These authorizations will remain in effect until I revoke them in writing at least 10 days prior to the date the account is scheduled to be charged. 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 total premium will be charged upon this application's acceptance.

Payment Option 1: Debit my bank account

Type of account: Checking Savings

I request and authorize Blue Cross and Blue Shield of North Carolina to use a bank draft to withdraw my initial payment and subsequent months' premiums from my bank account. I understand that the account listed cannot be my employer's account.

Name of bank: _____ Name of bank account holder: _____

Bank routing transit number:

This number appears in the lower left-hand corner of your check.

Bank account number:

This number appears to the right of the transit number and is separated from the transit number by symbols/spaces. Your number may be shorter than the boxes provided above.

Signature of Account Holder: _____ Date: MM / DD / YY

Payment Option 2: Charge my credit card for initial payment, then bill me monthly.

I request and authorize Blue Cross and Blue Shield of North Carolina to charge my credit card initially, then bill me monthly.

Type of credit card account MasterCard or Visa Name of credit card account holder: _____

Address to which credit card bill is sent:

Street or P.O. Box: _____ Apt. or suite: _____ City and State: _____ Zip Code: _____

Credit card number:

Expiration Date: MM / YY

Signature of Account Holder: _____ Date: MM / DD / YY

Section 6: Questions About Applicants' Health

Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information. Check (✓) No only if the question can be answered No for ALL applicants. Check (✓) Yes under the applicant or applicants for whom the condition applies.

Has anyone applying for coverage on this application been diagnosed with or treated for any of the following conditions and/or had any of the following procedures performed:

	Applicants					
	ALL No	Primary Yes	Spouse Yes	Child 1 Yes	Child 2 Yes	Child 3 Yes
1. Heart disease, heart attack, angina, angioplasty, stent placement, bypass surgery, coronary artery disease (CAD), heart failure, valvular heart disease, peripheral vascular disease (PVD) or polyarteritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. An abnormal heart rhythm or palpitations that requires treatment (including medications, pacemaker or surgery)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Hypertension or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. How many times in the past 12 months did you contact or visit your doctor to get a prescription for your hypertension, either to renew your current prescription, or get a different or additional prescription, or get samples to treat your hypertension? (Write a number in the red box to the right under each applicant for whom you checked Yes.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Lung disease, such as emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), interstitial lung disease (ILD) or fibrosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Any use of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Any inpatient treatment at a hospital for any of the above conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Abnormal lipids, including elevated cholesterol or elevated triglycerides, treated with medication within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Inpatient or outpatient treatment at a hospital for asthma OR taking daily medication to treat asthma within the past 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. a. Hepatitis A?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hepatitis D?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Muscular dystrophy, multiple sclerosis, cerebral palsy, Parkinson's disease, Alzheimer's disease, Lou Gehrig's disease (ALS), dementia, Myasthenia gravis or other immune deficiency disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chronic fatigue, fibromyalgia, Epstein Barr and/or chronic Lyme disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. a. Depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Anxiety/stress/panic disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Obsessive compulsive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Chemical imbalance or suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Any inpatient hospitalization for any of the conditions listed above in questions 10 a-e?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Brain damage, paralysis, stroke, transient ischemic attack (TIA) or hydrocephalus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Kidney stones or renal colic within the past 36 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Gall bladder disease, including gallstones, but has NOT had gall bladder removed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 6: Questions About Applicants' Health (continued)

Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information. Check (✓) No only if the question can be answered No for ALL applicants. Check (✓) Yes under the applicant or applicants for whom the condition applies.

Has anyone applying for coverage on this application been diagnosed with or treated for any of the following conditions and/or had any of the following procedures performed:

	ALL No	Applicants				
		Primary Yes	Spouse Yes	Child 1 Yes	Child 2 Yes	Child 3 Yes
14. Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. a. Colitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Irritable bowel syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Inflammatory bowel disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Familial polyposis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Osteoarthritis of the hips, knees or spine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Knee or hip joint replacement (total or partial), or recommended knee or hip joint replacement (total or partial)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Primary - Date of surgery: <u>MM / DD / YY</u>						
b. Spouse - Date of surgery: <u>MM / DD / YY</u>						
18. Arthritis, such as inflammatory arthritis, rheumatoid arthritis (RA), psoriatic arthritis, ankylosing spondylitis or systemic lupus erythematosus (SLE)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Diabetes mellitus, but NOT including gestational diabetes? If yes, answer a-c:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Date of diagnosis:		Primary - <u>MM / DD / YY</u>	Spouse - <u>MM / DD / YY</u>	Child 1 - <u>MM / DD / YY</u>	Child 2 - <u>MM / DD / YY</u>	Child 3 - <u>MM / DD / YY</u>
b. What is your most recent hemoglobin A1C (HgbA1C) reading? (This is not your blood sugar reading taken at home.)		Primary - _____	Spouse - _____	Child 1 - _____	Child 2 - _____	Child 3 - _____
c. Any complications such as retinopathy, circulatory disorders, ulcers, amputations or recommended amputations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Within the last five years has anyone been diagnosed with or had treatment (including surgery, radiation therapy or chemotherapy) for :						
a. Cancer/malignancy, including melanoma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Other forms of skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Prostate disorders, including enlarged prostate, benign prostatic hypertrophy or elevated PSA readings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Bleeding disorder, such as hemophilia or Von Willebrand's?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Sickle cell anemia, aplastic anemia or thalassemia major?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Moderate or severe psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Epilepsy or seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. If yes, was the most recent seizure within the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Has anyone who is less than 12 years of age had more than 3 ear infections in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 6: Questions About Applicants' Health (continued)

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Has anyone applying for coverage on this application been diagnosed with or treated for any of the following conditions and/or had any of the following procedures performed:

	Applicants					
	ALL No	Primary Yes	Spouse Yes	Child 1 Yes	Child 2 Yes	Child 3 Yes
29. Has anyone ever had the following procedures or treatments performed:	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
a. Spinal fusion?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
b. Gastric bypass or gastric restrictive procedures, such as lap band?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
c. Heart valve replacement?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
d. Cerebral shunt placement?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
e. Permanent colostomy/ileostomy?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
f. Surgery related to gastro esophageal reflux disorder (GERD)?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
g. Any internal organ transplant?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
h. Kidney dialysis and/or treatment for chronic renal failure/ end stage renal disease (ESRD)?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
i. Any past surgical procedure resulting in complications that still requires treatment?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
30. Has anyone been advised or scheduled to have surgery within the next 6 months?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
31. Within the last 12 months, has anyone seen an allergist or received an immuno-therapy injection?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
32. Has anyone been treated within the past 2 years for an eating disorder, such as anorexia or bulimia?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
33. Has anyone seen a chiropractor or physical therapist more than 5 times in the last 12 months?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
a. Primary - What was the date of your last visit: <u>MM / DD / YY</u>						
b. Spouse - What was the date of your last visit: <u>MM / DD / YY</u>						
c. Child 1 - What was the date of your last visit: <u>MM / DD / YY</u>						
d. Child 2 - What was the date of your last visit: <u>MM / DD / YY</u>						
e. Child 3 - What was the date of your last visit: <u>MM / DD / YY</u>						
34. Has anyone had any treatment in the last year for disc disorder of back or neck including surgery or injection therapy other than chiropractic care or physical therapy?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
35. More than 2 breast biopsies in the last 5 years?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
36. Within the past 12 months, has anyone had any treatment for heavy, frequent, and/or prolonged periods, uterine fibroids or endometriosis; but has NOT had a hysterectomy?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
37. Have either of your last two Pap smears been abnormal?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
38. Is anyone currently pregnant or an expectant parent (male or female)?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
39. Does anyone exercise for at least 20 minutes per day 3 or more times per week?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
40. Within the last 12 months, has anyone smoked cigarettes, marijuana, cigars, pipes or used chewing tobacco or snuff?	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y

Section 6: Questions About Applicants' Health (continued)

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Has anyone applying for coverage on this application been diagnosed with or treated for any of the following conditions and/or had any of the following procedures performed:

	Applicants					
	ALL No	Primary Yes	Spouse Yes	Child 1 Yes	Child 2 Yes	Child 3 Yes
41. Has anyone applying for coverage on this application taken, used, been prescribed or been advised to use any of the following categories of prescription medications within the last 12 months:						
a. Anti-depressant?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
b. Anti-psychotic (such as Risperdal®, Abilify® or Seroquel®) or anti-manic (such as Lamictal® or Lithobid®)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
c. Anti-anxiety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
d. Attention deficit disorder (ADD), or attention deficit hyperactivity disorder (ADHD) medication, such as Adderall®, Ritalin® or Concerta®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
e. Antabuse®, Suboxone or other medications used in the treatment of alcohol and/or drug addiction?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
f. Migraine medication?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
g. Blood thinner/anti-coagulant medication?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
h. Nitroglycerin, Digoxin or Lanoxin®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
i. Immune system medication, such as methotrexate, Imuran®, Cytoxan® or Zometa®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
j. Oral steroids taken or prescribed for daily use all year, or steroid injections taken for an ongoing condition that occurs during 3 or more separate treatment periods per year?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
k. Growth hormones, such as Humatrope®, Genotropin®, Nutropin® or Norditropin®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
l. Prescription gastrointestinal medication, such as Nexium®, Prilosec® or Prevacid®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
m. Injection medication prescribed for rheumatoid arthritis (RA), psoriasis, inflammatory bowel disease, ulcerative colitis or Crohn's disease, such as Arava®, Remicade®, Enbrel®, Plaquenil® or Hydroxychloroquine?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
n. Infertility medication?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
o. Pancreatic enzymes, such as Creon®, Pancrease®, Ultrase® or Lipram®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
p. Synagis® used to treat Respiratory Syncytial Virus (RSV)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
q. Procrit®, Epogen® or other medication to treat chronic kidney disease?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
r. Immunoglobulin therapy (such as IVIG or GammaGlobulin) or other immunobiologic agents (such as Adagen®, Polygam® or Gamunex®) used for the treatment of immune deficiency disorders or autoimmune disorders?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
s. Protein medications, such as Aralast®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
t. Medications used to treat pulmonary hypertension, such as Flolan®, Remodulin® or Tracleer®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
u. Xolair® or Omalizumab?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
v. Enzyme medications, such as Aldurazyme®, Fabrazyme® or Cerezyme®?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
w. Any medication to treat genital herpes, genital warts, human papillomavirus (HPV) or other sexually transmitted disease?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Section 6: Questions About Applicants' Health (continued)

Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information. Check (✓) No only if the question can be answered No for ALL applicants. Check (✓) Yes under the applicant or applicants for whom the condition applies.

Has anyone applying for coverage on this application been diagnosed with or treated for any of the following conditions and/or had any of the following procedures performed:

42. Does anyone 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?

ALL No	Applicants				
	Primary Yes	Spouse Yes	Child 1 Yes	Child 2 Yes	Child 3 Yes
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

Please describe how the physical or mental impairment substantially limits one or more of the major life activities stated previously:

If yes, is the physical or mental impairment temporary or correctable? Yes No

If yes, please explain how the physical or mental impairments are temporary or how the person plans to have it corrected:

Antabuse is a registered trademark of Duramed Pharmaceuticals, Inc. Tracleer is a registered trademark of Actelion Pharmaceuticals US, Inc. Lanoxin is a registered trademark of GlaxoSmithKline. Imuran is a registered trademark of Prometheus Laboratories, Inc. Polygam is a registered trademark of the American Red Cross. Adagen is a registered trademark of Enzon Pharmaceuticals, Inc. Gamunex is a registered trademark of Talecris Biotherapeutics. Cytoxan is a registered trademark of Mead Johnson and Company. Plaquenil and Arava are registered trademarks of Sanofi-Aventis US LLC. Humatrope is a registered trademark of Eli Lilly and Company. Genotropin is a registered trademark of Pfizer Inc. Nutropin is a registered trademark of Genentech, Inc. Norditropin is a registered trademark of Novo Nordisk. Remicade is a registered trademark of Centocor, Inc. Enbrel is a registered trademark of Immunex Corporation. Creon is a registered trademark of Solvay Pharmaceuticals. Pancrease is a registered trademark of Ortho-McNeil-Janssen Pharmaceuticals, Inc. Ultrase is a registered trademark of Axcan Pharma. Lipram is a registered trademark of Impax Laboratories, Inc. Synagis is a registered trademark of MedImmune LLC. Risperdal is a registered trademark of Janssen. Abilify is a registered trademark of Bristol Myers Squibb. Flolan and Lamictal are registered trademarks of GlaxoSmithKline. Lithobid is a registered trademark of Noven Pharmaceuticals, Inc. Adderall is a registered trademark of Teva Pharmaceuticals. Concerta is a registered trademark of McNeil Pediatrics. Ritalin and Zometa are registered trademarks of Novartis Pharmaceuticals Corp. Seroquel, Nexium and Prilosec are registered trademarks of Astra Zeneca Pharmaceuticals, LP. Prevacid is a registered trademark of Takenda Pharmaceuticals North America, Inc. Procrit is a registered trademark of Centocor Ortho Biotech, Inc. Epogen is a registered trademark of Amgen, Inc. Aralast is a registered trademark of Baxter Healthcare Corp. Remodulin is a registered trademark of United Therapeutics Corp. Xolair is a registered trademark of Genetech, Inc. and Novartis Pharmaceuticals Corp. Aldurazyme is a registered trademark of BioMarin/Genzyme LLC. Fabrazyme and Cerezyme are registered trademarks of Genzyme Corporation.

Section 7: Applicants' Other Healthcare Coverage

Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information. Check (✓) No only if the question can be answered No for ALL applicants.

Check (✓) Yes under the applicant or applicants for whom the condition applies.

1. Is anyone applying for coverage currently covered by Medicare benefits Part A and/or Part B?

ALL No	Applicants				
	Primary Yes	Spouse Yes	Child 1 Yes	Child 2 Yes	Child 3 Yes
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

2. Has anyone applying for coverage applied for or been accepted for Social Security disability?

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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3. Has anyone applying for coverage received a permanent disability rating with workers' compensation?

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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4. Is anyone applying for coverage currently covered by another health insurance program?

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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If you answered Yes, when you are approved for and accept this coverage, you must cancel any other health care coverage you have. If you keep your other health care coverage, this coverage will be terminated.

To receive portability credit, list all health care coverage that all applicants have had within the last 18 months, including prior BCBSNC coverage. BCBSNC may request a HIPAA certificate for verification purposes.

Previous Carrier Name and Address	Plan Term Dates Month Day Year	Applicants				
		Primary	Spouse	Child 1	Child 2	Child 3
Carrier name: _____	Effective Date MM / DD / YY					
Street or P.O. Box: _____						
City and State: _____ Zip Code: _____	Termination Date MM / DD / YY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policy holder's ID number: _____						
Carrier name: _____	Effective Date MM / DD / YY					
Street or P.O. Box: _____						
City and State: _____ Zip Code: _____	Termination Date MM / DD / YY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policy holder's ID number: _____						

Section 8: Statement of Understanding for Medical Coverage

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

1. I certify that all statements on this application are complete and true. I understand that Blue Cross and Blue Shield of North Carolina (BCBSNC) may rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. Additionally, for a period of two years from the date coverage is issued, BCBSNC may reform my coverage or deny claims for coverage if materially incorrect information has been given on this application.
2. I understand that the coverage applied for will not be issued unless the following conditions are met:
 - i) BCBSNC must receive a completed application and, if requested by BCBSNC, any medical records or other information,
 - ii) BCBSNC finds that I am eligible for this coverage as of the date of the application according to its policy and that I am insurable for this coverage.
3. I understand that I may be declined for coverage for health condition reasons. Rates upon issue may be higher than the original quoted rates. I understand that this application, along with the benefit booklet and the "Summary of Benefits," is the entire legal contract between BCBSNC and myself. I further understand that any coverage provided according to this application will be subject to the provisions of the benefit booklet, issued to me by BCBSNC.
4. 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 or I am an applicant under the age of 19. 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. Waiting periods do not apply to newborns, adoptive children, foster children, or applicants under age 19.
5. I understand that final rates cannot be determined until my application is processed and completed. I understand that once my application is approved and I have received my benefit booklet, 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.
6. If purchasing Blue Advantage or Blue Advantage Saver, I understand that this is not a high deductible health plan (HDHP) under the United States Tax Code, and therefore is not intended to be paired with a health savings account.
7. If purchasing Blue Options HSA, I understand that the health savings account (HSA) fund is provided to me directly by a separate Administrator that is unaffiliated with BCBSNC. The HSA is not part of the health benefit plan administered by BCBSNC. BCBSNC is not responsible or liable for administration of the fund. Detailed information regarding my HSA will be provided by that Administrator. BCBSNC will share certain personal information about me with such Administrator to facilitate the Administrator's establishment of my fund. By signing this application, I authorize BCBSNC to share pertinent information with the Administrator, which may include my name, address, and Social Security number.

The Blue Options HSA product is a high deductible health plan that qualifies its members to contribute to an HSA, unless its members are otherwise ineligible under applicable federal requirements. If unsure about whether ineligible, members should consult a qualified tax advisor.

By signing this application, I authorize the fund Administrator to establish an HSA fund on my behalf, as of the date corresponding with the effective date of my high deductible health plan with BCBSNC. In order to activate the fund, I will need to provide additional authorization through documents that will be provided to me by the fund Administrator.

If I choose to activate the fund, I will be issued a debit card in connection with my fund. I agree that although BCBSNC's name and marks may be included on the face of the debit card for my 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.

As the primary applicant, or parent/guardian of the primary applicant, I warrant that I am authorized to agree to the above statements on behalf of all my dependents under age 18. (Applicant Spouse and Applicant Dependents Age 18 or Older must sign below.)

Signature of Primary Applicant
or Signature of Parent/Guardian
(if applicant is under age 18): _____ Date: _____

Signature of Applicant Spouse: _____ Date: _____

Signature of Applicant
Dependent Age 18 or Older: _____ Date: _____

Signature of Applicant
Dependent Age 18 or Older: _____ Date: _____

Signature of Applicant
Dependent Age 18 or Older: _____ Date: _____

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

Section 9: BCBSNC/Producer Internal Use Only

I hereby certify that I have truly and accurately recorded the information supplied by the applicant.

Signature of Producer: _____

Print Name: **Drew E Partridge** Producer's (P) Number: **P0036204**

Date: _____ Producer's telephone number with area code: **704-947-8814**

AUTHORIZATION AND APPOINTMENT OF REPRESENTATIVE TO SUBMIT AN ELECTRONIC DOCUMENT AND SIGNATURE

I understand that by signing this form, I am agreeing to the following:

- I, Applicant, appoint the Blue Cross and Blue Shield of North Carolina ("BCBSNC") appointed producer named below to act as my representative ("Representative") for the express purpose of submitting certain written personal information provided by me to BCBSNC in an electronic format as part of the process of applying for and/or maintaining insurance coverage.
- I further appoint Representative to transmit/convert all personal information to electronic format ("Electronic Application") from the following paper application ("Paper Application"):
 Blue Advantage Blue Advantage Saver Blue Options HSA Dental Blue for Individuals Blue Medicare Supplement
 The personal information submitted by Representative shall be taken from the Paper Application after I read and accurately complete the Paper Application in its entirety and sign the Paper Application. Representative shall correctly, accurately and completely transmit/convert all of the information provided by me on the Paper Application in an electronic format to BCBSNC.
- I will provide Representative with unique personal data that will be used to create a personal electronic signature as part of this process of applying for insurance coverage with BCBSNC.
- Representative shall be granted permission to use my electronic signature, and Representative's use of my electronic signature shall constitute my authorization and shall be considered as my legally binding signature for my Electronic Application.
- Representative will provide me with copies of my completed Paper Application and this completed, signed authorization form.
- BCBSNC will provide me with a copy of my Electronic Application once my Application has been approved. I agree to compare my Paper Application to my Electronic Application to check for any inaccuracies.
- I have ten (10) days after receipt of my Electronic Application to notify BCBSNC that information on the Electronic Application is not accurate. If notice is not received by BCBSNC within the appropriate time frame, the Electronic Application shall be considered the accurate and original Application authorized and completed by me and for which I will be responsible.
- After my Electronic Application has been submitted to BCBSNC, but prior to my Application being approved by BCBSNC, Representative may contact me to discuss my Application. If I orally notify my Representative of my decision to choose a new plan, deductible, coinsurance, or effective date, to add/remove applicants or maternity rider, or any other benefit change(s) during this application process, I further appoint and authorize my Representative to translate/convert my requested oral change into an electronic format.

The above authorization will expire 90 days after the application submitted date.

Authorization for Benefit Changes Beyond Initial Application

I understand that by signing this form, I am agreeing to the following:

If enrolled on this policy, my Representative shall continue to be authorized to make benefit changes not involving disclosure of personal or privileged information, based on my oral notification. Such authorization will remain in effect until I instruct BCBSNC to remove this Representative as the agent on my policy.

As the primary applicant or parent/guardian of the primary applicant, I warrant that I am authorized to agree to the above statements on behalf of myself and all my dependents under age 18. (Applicant Spouse and Applicant Dependents Age 18 or Older must sign below.)

Print Applicant Names: _____

Signature of Primary Applicant or
Signature of Parent/Guardian
(if applicant is under Age 18): _____ Date: _____

Signature of
Applicant Spouse: _____ Date: _____

Signature of Applicant
Dependent Age 18 or Older: _____ Date: _____

Signature of Applicant
Dependent Age 18 or Older: _____ Date: _____

Signature of Applicant
Dependent Age 18 or Older: _____ Date: _____

I hereby certify that I will truly and accurately record the information supplied by the applicant.

Signature of Producer: _____ Date: _____

Print Name: **Drew E Partridge** Producer's (P) Number: **P0036204**

Producer: Please fax signed form to BCBSNC once the application is submitted. Application Number: _____

A copy of these authorizations shall be as valid as the original.

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