NORTH CAROLINA BAR ASSOCIATION HEALTH BENEFIT TRUST

ENROLLMENT and CHANGE APPLICATION

☐ **Change Request:** For changes, complete sections **A**, **B**, and all other applicable sections

Completed by Group Administrator only	
EFFECTIVE DATE (MM/DD/YYYY)	GROUP NUMBER

INSTRUCTIONS: **ALL** new employees complete **B**, **C**, **D**, **E**, **F**, **G**

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

CHECK ALL THAT APPLY

- ☐ Name Change
- ☐ Address Change
- ☐ Telephone Change
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ Open Enrollment
- ☐ Other Insurance Information

☐ **ADD COVERAGE** — **Date of Qualifying Event**

- ☐ Marriage _____
- ☐ Death _____
- ☐ Newborn _____
- ☐ Other: _____

_____ _____

QUALIFYING EVENT

- ☐ Change in Marital Status
- ☐ Change in Employment Status
- ☐ Change in Residence Affecting Carrier Coverage
- ☐ FMLA Eligibility
- ☐ Other Employer Plan Changes
- ☐ COBRA Qualifying Event
- ☐ Medicare Entitlement
- ☐ Change in Dependents
- ☐ Change in Eligibility Status for Coverage
- ☐ Significant Cost Change in Existing Coverage
- ☐ Court Orders / Judgments
- ☐ Open Enrollment
- ☐ Loss of Coverage Under Another Group Plan
- ☐ Other Federal / State Law Allowance

B. EMPLOYEE INFORMATION

☐ Active Employee
☐ COBRA / State Continuation:

DATE CONTINUATION STARTED (mm/dd/yyyy)	DATE CONTINUATION ENDS (mm/dd/yyyy)	WHAT WAS THE DATE OF THE QUALIFYING EVENT?
____/____/____	____/____/____	____/____/____

FIRST NAME / MIDDLE INITIAL	LAST NAME	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTHDATE (mm/dd/yyyy)
			____/____/____

ADDRESS / APT. NO.	CITY	COUNTY	STATE AND ZIP

☐ MALE ☐ FEMALE	HEIGHT	WEIGHT	HOME PHONE NUMBER	WORK PHONE NUMBER	OCCUPATION
			( )	( )	

E-MAIL ADDRESS

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

FIRM NAME	WORK LOCATION	DATE OF FULL TIME EMPLOYMENT (mm/dd/yyyy)
		____/____/____

C. COVERAGE SELECTION

COVERAGE **(check only one medical plan):**

☐ **Plan 1** ☐ **Plan 2** ☐ **Plan 3** ☐ **Plan 4** ☐ **Plan 5** ☐ **Plan 10 HSA Eligible** ☐ **Plan 20 HSA Eligible** ☐ **Plan 15 HSA Eligible**

☐ Employee Only ☐ Employee and Family ☐ Employee and Spouse ☐ No Medical Benefits ☐ Employee and Child(ren)

D. FAMILY INFORMATION - Complete for anyone taking Health Coverage

- List family members taking health coverage.
- Handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents.

NAME (First, Middle Initial, Last)	**SOCIAL SECURITY NUMBER** (required for spouse)	**BIRTHDATE** (mm/dd/yyyy)	**SEX**	**HEIGHT**	**WEIGHT**	**CHILD STATUS*** (if applicable)
SPOUSE			☐ MALE ☐ FEMALE			
CHILD **1**			☐ MALE ☐ FEMALE			☐ FOSTER ☐ ADOPTED ☐ HANDICAPPED** ☐ UNDER AGE 26**
CHILD **2**			☐ MALE ☐ FEMALE			☐ FOSTER ☐ ADOPTED ☐ HANDICAPPED** ☐ UNDER AGE 26**
CHILD **3*** **			☐ MALE ☐ FEMALE			☐ FOSTER ☐ ADOPTED ☐ HANDICAPPED** ☐ UNDER AGE 26**

* Consult your employer regarding dependent eligibility requirements. Supporting documentation may be required.
** A request for coverage (form P24) is required if your child is 26 years or older and will be reviewed to determine eligibility.
*** If you have more than three children, complete **Section C** on another application.

E. OTHER HEALTH INFORMATION

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 your 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, placement for adoption, or due to a court order, 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. Eligible children who are added as a result of a court order are not subject to this enrollment period restriction.

Notice of Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

For questions or to obtain more information, contact:

North Carolina Bar Association Health Benefit Trust
c/o Lawyers Insurance Agency
8000 Weston Parkway, Suite 200
Cary, NC 27513
1-800-662-8843 (toll-free)

E2. OTHER HEALTH INSURANCE

This section MUST be completed if you will have additional insurance in force during this new policy.

Will you or your covered dependents have other insurance in addition to this policy? ☐ Yes ☐ No

Are any dependents covered under another plan due to divorce/separation? ☐ Yes ☐ No **IF YES TO EITHER QUESTION, complete E2 below**

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY	POLICYHOLDER NAME AND DATE OF BIRTH (mm/dd/yyyy)
	____/____/____

Application is continued on reverse side →

Employee Name: _____

POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE	If Individual coverage check here ☐	POLICY NUMBER

POLICY HOLDER'S SOCIAL SECURITY NUMBER	EFFECTIVE DATES OF COVERAGE (mm/dd/yyyy)
	From: ____/____/____ **To:** ____/____/____

INDIVIDUALS COVERED	FAMILY MEMBERS COVERED BY MEDICARE

MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO:	**PART A** EFFECTIVE DATE (mm/dd/yyyy)	**PART B** EFFECTIVE DATE (mm/dd/yyyy)
	☐ RENAL DISEASE **FIRST DAY OF DIALYSIS** ____/____/____ ☐ AGE ☐ DISABILITY	____/____/____	____/____/____

F. COVERAGE SELECTION Underwritten by: ■ USAble Life for Life, AD&D

Coverage Selection: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

Life/AD&D ..... ☐ **Yes** ☐ **No**
Dependent Life ..... ☐ **Yes** ☐ **No**
☐ **$10,000/$5,000** ☐ **$20,000/$10,000**
Supplemental Life / AD&D..... ☐ **Yes** ☐ **No**

Not available if spouse or child is also eligible for insurance under this policy as an employee

Amount: _____

☐ **NO BENEFITS SELECTED**

PRIMARY BENEFICIARY NAME AND ADDRESS **(REQUIRED)**

RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	PERCENT[1]

CONTINGENT BENEFICIARY NAME AND ADDRESS **(REQUIRED)**

RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	PERCENT[1]

- I understand that if I selected Life that I will be covered by USAble Life.
- I understand that if I am not actively at work as defined in the policy (coverage listed in Section F of this application) 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, a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

X Signature: _____ **Date:** MM / DD / YYYY

F. COVERAGE SELECTION Underwritten by: ■ USAble Life for Life, AD&D

I understand that the benefits for which I (we) will be eligible are those described in the Administrative Services Agreement and/or the life insurance carrier 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 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.

HSA PLANS ONLY:

I understand that if I am applying for an HSA Eligible product offered by North Carolina Bar Association Health Benefit Trust ("PLAN"), the HSA is provided to me directly by a separate administrator, unaffiliated with PLAN or Blue Cross and Blue Shield of North Carolina ("BCBSNC"), and is not part of PLAN. PLAN and BCBSNC are not responsible or liable for administration of the HSA. Detailed information regarding my HSA will be provided by that 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 selects a BCBSNC fund administrator for my HSA, BCBSNC, my employer, PLAN or their designees will share certain personal information about me with such administrator to facilitate the administrator's establishment of the HSA account. By signing this application, I authorize BCBSNC, my employer, PLAN or their designees to share pertinent information with such administrator 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, 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.

I understand that PLAN and BCBSNC take 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 HSA Administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my High Deductible Health Plan with PLAN. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the HSA 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.

X Employee Signature: _____ **Date:** MM / DD / YYYY