

ENROLLMENT and **CHANGE APPLICATION**

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

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					

A. IF MAKING A CHAN	NGE FROM PR	REVIOUS EN	ROLLMENT						
CHECK ALL THAT APPLY	ADD COVE	ERAGE	Date of Qualifying	g Event	QU	JALIFYING			
Name Change	Marriad	ne				1	Marital Sta		Significant Cost Change in Existing Coverage
Address Change		90					Employme Residence		Court Orders / Judgments
Telephone Change	Death				_ _	Carrier Co	verage	Affecting	Open Enrollment
Replace ID Card						FMLA Elig	•		Loss of Coverage Under Another Group Plan
Date of Birth Correction	Newbo	orn			- -		ployer Plan	-	Other Federal / State Law Allowance
Open Enrollment	Other:					1	tualifying Ev Entitlement		Allowance
	Other.				ᅵ├	,	Dependen		
Other Insurance Information					_ -	, ,		Status for C	overage
B. EMPLOYEE INFORM	MATION					, , ,	3 ,		
	DATE CONTINUA	ation startei	D (mm/dd/yyyy) DA	ATE CONTINUAT	TION EN	IDS (mm/do	d/yyyy) WH	IAT WAS TH	HE DATE OF THE QUALIFYING EVENT?
COBRA /		,		,					
State Continuation:	/_	/		/	/_		_		//
FIRST NAME / MIDDLE INITIA	AL LAST NA	AME	•	Ef	MPLOYE	E SOCIAL	SECURITY N	NUMBER	EMPLOYEE BIRTHDATE (mm/dd/yyyy)
ADDRESS			APT. NO. CI	TY			COUN	ITY	STATE AND ZIP
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MALE HEIGHT	WEIGHT	HOME PHONE	NUMBER	WORK PHONE	E NUMB	ER	OCCUP	PATION	
FEMALE		()		()					
E-MAIL ADDRESS						M	arital [SINGLE	MARRIED WIDOWED
							ATUS	SEPARAT	TED DIVORCED
FIRM NAME			WOF	RK LOCATION				DATE OF F	FULL TIME EMPLOYMENT (mm/dd/yyyy)
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C. COVERAGE SELECT	ION							_	
COVERAGE SELECT		١.			_				
			□ pl 20	O LICA Elbadala			oyee Only		Employee and Family
Plan 1 Plan 3	☐ Plan 5	0 HSA Eligib	=	0 HSA Eligible 5 HSA Eligible			oyee and	•	No Medical Benefits
				o 115A Eligible	·	Empl	oyee and	Child(ren)	
D. FARALLY INFORMAT	'ION CI								
	-		ne taking Health	Coverage					
• List family members tak	ing health cove	erage.			aible de	ependent	age maxir	num in po	olicy documents.
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I understand that PLAN and BCBSNC take no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax at 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 corresponding with the effective date of my High Deductible Health Plan with PLAN. In order to activate the account, I will need to provide add authorization through documents that will be provided to me by the HSA Administrator.								alf, as of the dat	te		
I certify that all statements	s made herein are co	omplete and true	to the best o	f my know	wledge	e and my signatu	re autho	rizes al	l sections	of this applicati	ion.
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