NORTH CAROLINA BAR ASSOCIATION
HEALTH BENEFIT TRUST

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 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 Dependent(s):	**Date of Occurrence (mm/dd/yyyy):**
☐ Marriage	______
☐ Newborn	______
☐ Adoption	______
☐ Other:	______
______	______
______	______

☐ Elect COBRA Coverage

QUALIFYING EVENT:
☐ Termination of Employment
☐ Reduction in Hours
☐ Divorce
☐ Medicare Eligible
☐ Social Security Disability Determination
☐ Overaged Dependent Now Eligible
☐ Death

Reinstate Coverage:
☐ Return from Layoff
☐ Return from Leave
☐ Retirement
☐ Disenrollment Error
☐ Other: ______
______
☐ Rehired Date:
______

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	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 3** ☐ **Plan 10 HSA Eligible**
☐ **Plan 2** ☐ **Plan 4** ☐ **Plan 20 HSA Eligible**

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

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**	**CHILD STATUS*** (if applicable)
SPOUSE			☐ Male ☐ Female	
CHILD **1**			☐ Male ☐ Female	☐ Adopted ☐ Foster ☐ Handicapped**
CHILD **2**			☐ Male ☐ Female	☐ Adopted ☐ Foster ☐ Handicapped**
CHILD **3*** **			☐ Male ☐ Female	☐ Foster ☐ Foster ☐ Handicapped**

* Consult your employer regarding dependent eligibility requirements.
** A Coverage Request for Mentally Retarded or Physically Handicapped Children (P24) is required.
*** If you have more than three children, complete **Section D** on another application.

E. Other Health Insurance Information and Prior Health Insurance Information

E1. Prior Health Insurance <u>This section **MUST** be completed to receive credit for prior coverage and REDUCE or ELIMINATE any applicable waiting period.</u>

Have you had any health insurance within the last sixty-three (63) days? ☐ Yes ☐ No **If YES, complete below:**

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

EFFECTIVE DATE (mm/dd/yyyy) ___/___/___	TERMINATION DATE OR EXPECTED TERMINATION DATE (mm/dd/yyyy) ___/___/___	← *If other coverage will remain in effect, write N/A in term box, and complete section below.*

FAMILY MEMBERS COVERED **LIST NAMES AND RELATIONSHIPS**:

Employee Name: ______________________

F. Coverage Selection   Underwritten by: ☐ USAble Life for Life, AD&D

Coverage Selection: You 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** **Not available if spouse or child is also eligible for insurance under this policy as an employee**
Supplemental Life / AD&D......... ☐ **Yes** ☐ **No** **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

G. Statement of Understanding and Authorization

I understand that the benefits for which I (we) will be eligible are those described in the Group Contract and/or the life insurance carrier contract and any changes provided for therein. I understand that the North Carolina Bar Association Health Benefit Trust ("Plan") 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, the Plan may reform my coverage or deny claims for coverage if materially incorrect information has been given on this application.

HSA Plans Only:

I understand that if I am applying for an HSA Eligible product offered by 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