PPO ENROLLMENT APPLICATION

RETURN APPLICATION TO THE HUMAN RESOURCES REPRESENTATIVE.
PLEASE TYPE OR PRINT CLEARLY • DO NOT WRITE IN SHADED AREAS

Is rehire within 12 months of previous State enrollment or employment? ☐ Yes ☐ No

1	SOCIAL SECURITY NUMBER	EMPLOYEE LAST NAME	FIRST NAME		INITIAL
2	**MARITAL STATUS:** ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ MARRIED ☐ WIDOWED				
3	BIRTHDATE ____ ____ ____	SEX ☐ MALE ☐ FEMALE	TELEPHONE *(HOME)*	TELEPHONE *(WORK)*	
4	MAILING ADDRESS: BOX/STREET/ROUTE NUMBER	CITY	COUNTY	STATE	ZIP CODE
5	DOES WAITING PERIOD APPLY? ☐ YES ☐ NO				
6	**PLAN SELECTION:** ☐ Smart Choice Basic 70/30 ☐ Smart Choice 80/20 ☐ Smart Choice Plus 90/10				
7	**TYPE OF COVERAGE REQUESTED:** ☐ EMPLOYEE ONLY ☐ EMPLOYEE/CHILD(REN) ☐ EMPLOYEE/SPOUSE ☐ EMPLOYEE/FAMILY				

DEPENDENT INFORMATION → **List dependents to be included.**
Specify last name if different. Complete Certification of Dependent Eligibility Form for any starred (*) items checked.

	NAME *(FIRST, MIDDLE INITIAL, LAST)*	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	CHILD IS MY:	COMPLETE BELOW IF CHILD IS OVER 19	MEDICARE ELIGIBLE?	EMPLOYING UNIT MUST COMPLETE: DOES WAITING PERIOD APPLY?
8	SPOUSE		MONTH DAY YEAR	☐ MALE ☐ FEMALE			☐ YES *(see lines 13 & 14)* ☐ NO	☐ YES ☐ NO
9	CHILD 1		MONTH DAY YEAR	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER* ☐ ADOPTED ☐ STEP	☐ STUDENT *(see line 12)* ☐ HANDICAPPED	☐ YES *(see lines 13 & 14)* ☐ NO	☐ YES ☐ NO
10	CHILD 2		MONTH DAY YEAR	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER* ☐ ADOPTED ☐ STEP	☐ STUDENT *(see line 12)* ☐ HANDICAPPED	☐ YES *(see lines 13 & 14)* ☐ NO	☐ YES ☐ NO
11	CHILD 3		MONTH DAY YEAR	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER* ☐ ADOPTED ☐ STEP	☐ STUDENT *(see line 12)* ☐ HANDICAPPED	☐ YES *(see lines 13 & 14)* ☐ NO	☐ YES ☐ NO
12	**IF FULL-TIME STUDENT, LIST DEPENDENT'S FIRST NAME AND UNIVERSITY, COLLEGE OR ACCREDITED VOCATIONAL SCHOOL**							

MEDICARE INFORMATION → List below yourself and any other persons to be covered who are eligible for Part A and/or B of Medicare.

	NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO:	EFFECTIVE DATE ENROLLED FOR PART A (MM/DD/YY)	EFFECTIVE DATE ENROLLED FOR PART B (MM/DD/YY)
13			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	____ ____ ____	____ ____ ____
14			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	____ ____ ____	____ ____ ____

15 **OTHER GROUP HEALTH COVERAGE:** → ☐ No ☐ Yes — Complete the Prior Coverage/Other Coverage Information Form if you or your dependents have other group health coverage in effect, or if you or your dependents had other coverage that ended within the past 63 days.

16 COMMENTS

EMPLOYEE AUTHORIZATION

I hereby elect coverage under the plan listed above for myself and eligible family dependents listed on the form above, and I agree that all information provided is correct. I further agree that we shall abide by the provisions of the Agreement for the plan.

I hereby authorize my employer to deduct from my earnings any deduction for the coverage elected above.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medically-related facility, insurance company, or other organization or institution that has any records or knowledge of the health of any covered member of my family to exchange such information with the plan.

Employee's Signature _____ Date Signed ____/____/____ Desired effective date of coverage ____/ 01 /____

EMPLOYING UNIT MUST COMPLETE	EMPLOYING UNIT NAME	DOES MEDICARE REDUCED RATE APPLY? ☐ YES ☐ NO	GROUP NUMBER	PAYROLL NUMBER	DEPARTMENT NUMBER
	EMPLOYEE DEDUCTION	EMPLOYER CONTRIBUTION	DATE OF EMPLOYMENT	EFFECTIVE DATE	PART-TIME TO FULL-TIME EMPLOYMENT DATE
	$	$			

BlueCross BlueShield of North Carolina

North Carolina State Health Plan

North Carolina HEALTH Smart

INSTRUCTIONS TO COMPLETE THE PPO ENROLLMENT APPLICATION

Top of Form — Human Resources Representative checks whether the enrollee is a rehire within 12 months of termination of previous State enrollment or employment.

Line 1 — Fill in your social security number and name.

Line 2 — Check the appropriate box for marital status.

Line 3 — Fill in your date of birth and check the appropriate box for sex. Print your home and work phone numbers.

Line 4 — Fill in your address.

Line 5 — Completed by Human Resources Representative, if applicable.

Line 6 — Check your PPO Plan option.

Line 7 — Check the type of coverage desired. If you want employee/child(ren) coverage, list the name(s) of the child(ren) to be covered on lines 9 through 11. If you want employee/spouse coverage, give information about your spouse on line 8. If you want to include your spouse and child(ren), check the "employee/family" box and give the information about your spouse on line 8 and your child(ren) on lines 9 through 11.

Line 8 — If you want coverage for your spouse, give his/her first name, middle initial, and last name, if it is different from yours, and your spouse's social security number. Enter your spouse's date of birth and sex. Check "yes" or "no" to indicate whether your spouse is eligible for Medicare. If "yes" is checked, complete lines 13 or 14.

Your Human Resources Representative will complete the waiting period information, if applicable.

Lines 9 through 11 — If you want coverage for your eligible dependent child(ren), print each child's name, middle initial, and last name, if it is different from yours, and the child's social security number. Enter each child's date of birth and sex. Check the box that most accurately describes this child's relationship to you. If you have a child over 19 who is a full-time student and eligible to be covered, check "student." Check "yes" or "no" to indicate whether your child is eligible for Medicare. If "yes" is checked, complete line 13 or 14.

For each child whose last name is different from yours, give the child's last name and complete a Certification of Dependent Eligibility Form (available from your Human Resources Representative). Attach it to this application.

If you have a child over 19 who is eligible as a mentally or physically incapacitated dependent, check "handicapped" and fill out a Coverage Request for Mentally or Physically Incapacitated Children (available from your Human Resource Representative). Attach it to this application.

Your Human Resources Representative will complete the waiting period information, if applicable.

Line 12 — If you checked "student" for any dependent child(ren) listed on lines 9 through 11, give the dependent's name and the name of the accredited school or college that the dependent is attending.

Lines 13 and 14 — If you, your spouse, or any of your children listed on lines 9 through 11 are eligible for Medicare, give the name, Medicare claim number, reason for Medicare eligibility, and the dates enrolled in Part A and Part B for each person who is eligible for Medicare.

Line 15 — Check "yes" or "no" to indicate whether any participant listed to be covered has other employer-sponsored group health coverage.

If "yes" is checked, complete the Prior/Other Coverage Information form (available from your Human Resources Representative). Attach it to this application.

Employee Authorization — Read this statement, sign and date the form. Fill in the desired effective date of coverage. Your Human Resources Representative will complete the remaining information. Return the form to your Human Resources Representative or the State Retirement System. If you have questions about this form, contact your Human Resources Representative or Customer Service at **1-888-234-2416**.