BlueCross BlueShield of North Carolina

Please visit our web site at ***studentbluenc.com/uncch-ta***

Blue Options℠ Application
UNC Chapel Hill 2017-2018

PLEASE PRINT CLEARLY.

Section I Primary Applicant Information

LAST NAME | FIRST NAME | MIDDLE INITIAL

MAILING ADDRESS *(STREET, ROUTE, BOX NUMBER, ETC.)*

BIRTH DATE MONTH DAY YEAR

CITY | STATE | ZIP

SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER | STUDENT I.D. NUMBER (Required) | EMAIL ADDRESS

AREA CODE | TELEPHONE NUMBER | DEPARTMENT AFFILIATION

Section II Dependent Information

Please fill in all information for each person who is applying for coverage. Please see the legal notice on the reverse side of this application regarding special enrollment.

Name (First, Middle Initial, Last)	Status	Social Security Number	Birthdate Month Day Year	Sex	Handicapped
Spouse / Domestic Partner	☐ Single ☐ Domestic Partner ☐ Married ☐ Separated	– –	/ /	M ☐ F ☐	
Dependent Child 1*	☐ Biological ☐ Adopted ☐ Step ☐ Foster ☐ Legal Custody	– –	/ /	M ☐ F ☐	☐
Dependent Child 2*	☐ Biological ☐ Adopted ☐ Step ☐ Foster ☐ Legal Custody	– –	/ /	M ☐ F ☐	☐
Dependent Child 3*	☐ Biological ☐ Adopted ☐ Step ☐ Foster ☐ Legal Custody	– –	/ /	M ☐ F ☐	☐

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 BCBSNC at **1-800-579-8022**.
*An eligible dependent child is defined as under age 26 or handicapped.

Section III Premium Rate Selection

☐ SPOUSE/DOMESTIC PARTNER
☐ CHILD/CHILDREN

☐ **ANNUAL** ☐ **MONTHLY BANK DRAFT** **BEGINNING:** MONTH DAY YEAR

Section IV Statement of Understanding

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

I understand that the coverage applied for will not be issued unless BCBSNC finds that I am eligible for this coverage as of the date of the application according to its policy.

I understand that as long as I am enrolled in this coverage, I will not be eligible to enroll in any other BCBSNC or any other Blue Cross or Blue Shield plan.

I certify that all statements on this application are complete and true. ***I understand that for a period of two years from the date of this application, Blue Cross and Blue Shield of North Carolina (BCBSNC) may rescind my policy for any 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.*** *I understand that any coverage provided according to this application will be subject to the provisions of the contract including the benefit booklet provided to me by BCBSNC.*

SIGNATURE OF PRIMARY APPLICANT OR PARENT/GUARDIAN (IF APPLICANT IS UNDER AGE 18) | **DATE** MONTH DAY YEAR

Section V Monthly Bank Draft

IMPORTANT: Please enclose a check marked "VOID" for the account from which funds are to be drafted. At enrollment, current amount due will be drafted from the authorized account. All subsequent drafts will take place on the first business day of the month. I hereby authorize UNC Chapel Hill RA/TA Medical Insurance Plan to draft funds from my account beginning August 2017, through July 2018.

SIGNATURE OF ACCOUNT HOLDER | **DATE** MONTH DAY YEAR

PLEASE PRINT NAME

Application is continued on the reverse side.

Mailing Address: Blue Cross and Blue Shield of North Carolina, PO Box 2073, Durham, NC 27702
Questions? Call Blue Cross and Blue Shield of North Carolina at 1-800-579-8022 or email@studentbluenc.com

IMPORTANT LEGAL NOTICES
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 foster care, or by court order, you may be able to enroll yourself and your dependents. You must request enrollment within 30 days after the qualifying life event, unless adding a dependent child will not change your coverage type or premiums that are owed.

For questions or to obtain more information, contact:

Blue Cross and Blue Shield of North Carolina

PO Box 2073, Durham, NC 27702

1-800-579-8022

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.

- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

  ➢ BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com

- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.

- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019**, **800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

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BlueCross BlueShield of North Carolina

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY 1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。