☐ **NEW ENROLLEE**
(Please Complete A, C, D and E)

☐ **CHANGE REQUEST**
(For changes, complete Sections A, B and all other applicable sections)

Blue20/20℠ Application / Change Form

A. EMPLOYEE INFORMATION

Name of Employer:	Blue 20/20 Group No. (if known):	Effective Date:	Dept. / Division:

Social Security Number:	Date of Birth:	Sex: ☐ Male ☐ Female

Last Name:	First Name:	MI:	Marital Status: ☐ Single ☐ Married

Mailing Address:	City:	State:	Zip Code:

Date Employed (minimum of 30 hours):	Employee ID Number:	Blue 20/20 ID Number (if applicable):

Home Phone Number: ( )	Work Phone Number: ( )	E-Mail Address:

B. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

Check All That Apply:

☐ Name Change
☐ Employee SSN Correction
☐ Add/Remove Dependent
☐ Address/Telephone Number Change
☐ Replace ID Card
☐ Date of Birth Correction
☐ E-Mail Address
☐ Late Enrollee
☐ COBRA
☐ Other: ______________________

Add Dependent(s):

	Date of Occurrence
☐ Marriage	______________
☐ Newborn (up to age 1)	______________
☐ Adoption	______________
☐ Court Order	______________
☐ Other	______________

Remove Dependent(s):

	Date of Occurrence
☐ Divorce	______________
☐ Death	______________
☐ Obtained full-time employment	______________
☐ Obtained other coverage	______________
☐ Other ______________	______________

Reinstate Coverage:

Reason: ______________________

Cancel Coverage:

☐ Not Eligible
Reason: ______________________
______________ date

☐ Subscriber Request
______________ date

☐ Other ______________
______________ date

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Visit us at ***bcbsnc.com***

BlueCross BlueShield of North Carolina

F122, 9/11

C. COVERAGE SELECTION

Options Selected: ☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee and Family

Plan Option Selected: ☐ Blue 20/20 Exam Only ☐ Blue 20/20 Exam Plus ☐ Blue 20/20 Lens and Frames Only

I authorize payroll deduction for the vision plan in the amount of $___________ per month.

Once you elect vision coverage, you cannot cancel for a 12 month period based upon your enrollment date. Deductions are adjusted according to payroll frequency. I understand that future rates for 12 month renewal of this plan will be negotiated between my employer and BCBSNC.

D. FAMILY INFORMATION – Complete for anyone taking or dropping Blue 20/20 Coverage*

	Name (First, MI, Last Name)	Social Security Number	Date of Birth mm/dd/yyyy	Relationship	Sex
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M

* Application does not guarantee enrollment.

E. STATEMENT OF UNDERSTANDING

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina (BCBSNC) contract (including the benefit booklet) and 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 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.

_______________________________________ ____________________

Signature of Employee Date

Questions? Call Blue Cross and Blue Shield of North Carolina at 1-888-723-4476