North Carolina State Health Plan
for Teachers and State Employees
www.shpnc.org

ENROLLMENT APPLICATION

Have you been hired within 12 months of previous State employment termination? ☐ Yes ☐ No

☐ **DECLINE COVERAGE**

PLEASE TYPE OR PRINT CLEARLY IN BLUE OR BLACK INK • DO NOT WRITE IN SHADED AREAS

1	SOCIAL SECURITY NUMBER	EMPLOYEE LAST NAME	FIRST NAME	INITIAL
2	MAILING ADDRESS: BOX/STREET/ROUTE NUMBER	CITY	STATE	ZIP CODE
3	TELEPHONE *(HOME)*	TELEPHONE *(WORK)*	BIRTHDATE MONTH DAY YEAR ___/___/___	GENDER ☐ MALE ☐ FEMALE
4	**Type of Coverage Requested** ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Family			
5	**Plan Selection** ☐ 70/30 Basic ☐ 80/20 Standard			

DEPENDENT INFORMATION → **List dependents to be included.** Complete Certification of Dependent Eligibility Form for foster children.

	NAME *(FIRST, MIDDLE INITIAL, LAST)*	SOCIAL SECURITY NUMBER	BIRTHDATE	GENDER	CHILD IS MY	COMPLETE ONLY IF CHILD IS OVER 19	MEDICARE ELIGIBLE?	DOES WAITING PERIOD APPLY?
6	SPOUSE		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE			☐ YES (see lines 11 & 12) ☐ NO	☐ YES ☐ NO
7	CHILD 1		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 10) ☐ HANDICAPPED	☐ YES (see lines 11 & 12) ☐ NO	☐ YES ☐ NO
8	CHILD 2		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 10) ☐ HANDICAPPED	☐ YES (see lines 11 & 12) ☐ NO	☐ YES ☐ NO
9	CHILD 3		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 10) ☐ HANDICAPPED	☐ YES (see lines 11 & 12) ☐ NO	☐ YES ☐ NO
10	**IF FULL-TIME STUDENT, LIST DEPENDENT'S NAME AND ACCREDITED INSTITUTION**							

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

	NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO:	EFFECTIVE DATE ENROLLED PART A (MM/DD/YY)	EFFECTIVE DATE ENROLLED PART B (MM/DD/YY)
11			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	___/___/___	___/___/___
12			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	___/___/___	___/___/___

13	**OTHER GROUP HEALTH COVERAGE** →	**A BOX MUST BE SELECTED IN ORDER FOR YOUR APPLICATION TO BE PROCESSED.** 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.	☐ No ☐ Yes
14	COMMENTS		

EMPLOYEE AUTHORIZATION

I hereby elect coverage under the plan option 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 provision of the Agreement for the selected plan option.

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 State Health Plan.

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

EMPLOYING UNIT MUST COMPLETE

SECTION NUMBER	Does Waiting Period Apply? ☐ Yes ☐ No				
EMPLOYING UNIT NAME	GROUP NUMBER	DOES MEDICARE REDUCED RATE APPLY? ☐ YES ☐ NO	PAYROLL NUMBER		
EMPLOYEE DEDUCTION $	EMPLOYER CONTRIBUTION $	HIRE DATE	EFFECTIVE DATE	PART-TIME TO FULL-TIME EMPLOYMENT DATE	

C9, 5/10

BlueCross BlueShield of North Carolina

Blue Cross and Blue Shield of North Carolina, the North Carolina State Health Plan and North Carolina HealthSmart are not affiliated. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

North Carolina HEALTH Smart

PINK COPY should be retained by the employee and used as a temporary ID card. Submit WHITE and YELLOW COPY to employing unit