

Enrollment/Change Application

Completed by Group Administrator Only	
Group Number (if applicable):	Blue Cross NC Subscriber ID Number (if available):

Instructions:

- All employees applying for medical coverage complete Sections **A, B** (if applicable), **C** (if applicable), **D, E, F, H, I**.
- For change requests, complete Sections **A, C** and all other applicable sections.
- If declining medical coverage, please complete Sections **A** and **D**.
- For help in reading this notice, Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides consumer assistance tools and services for individuals living with disabilities (including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. Blue Cross NC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call **877-258-3334**. For TTY and TDD, call **800-442-7028**.

Please type or print in black or blue, NOT RED ink

A. Employee Information

First Name		Middle Initial	Last Name			Suffix
Employee Birthdate	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy	Employee Social Security Number			<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status
Address		P.O. Box (For Blue Options HSA / HSA eligible plans you must also provide a street address.)	Apt. No.	City	State	Zip Code
Company Name			Occupation			
Work Location	Date of Full Time Employment	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy	Language Preference			
<input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other _____		Home Phone Number		Work Phone Number	E-Mail	
() ()		() ()		() ()		
Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.)						
<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Choose not to report <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other (specify) _____						
<input type="checkbox"/> Active Employee <input type="checkbox"/> Cobra/State Continuation <input type="checkbox"/> Retiree (51+)						
COBRA/State Continuation Qualifying Life Event (OLE):						
<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Divorce <input type="checkbox"/> Over Age Dependent <input type="checkbox"/> Medicare Eligible						
What was the date of the OLE?		Date Continuation Started	Date Continuation Ends			
<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy		<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy			

B. If Enrolling Due to a Qualifying Life Event

You may apply for coverage for yourself or a dependent outside of open enrollment due to a qualifying life event within 30 days of the date of the event (unless 60 days is required by law). (Legal documentation may be required.) Please fill out this section unless otherwise instructed by your Group Administrator.

Adding a dependent due to:

<input type="checkbox"/> Marriage	Date of Occurrence	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy	<input type="checkbox"/> Adoption	Date of Occurrence	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy	<input type="checkbox"/> Court Order	Date of Occurrence	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy
<input type="checkbox"/> Birth	Date of Occurrence	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy	<input type="checkbox"/> Foster Placement	Date of Occurrence	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy	<input type="checkbox"/> Other	Date of Occurrence	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy

Enrolling and/or adding a dependent due to loss of other coverage as a result of:

<input type="checkbox"/> Exhaustion of COBRA Continuation	<input type="checkbox"/> Divorce	<input type="checkbox"/> Loss of dependent status	<input type="checkbox"/> Death	<input type="checkbox"/> Meeting or exceeding the lifetime benefit maximum of other plan
<input type="checkbox"/> Reduction in hours	<input type="checkbox"/> Termination of other coverage	<input type="checkbox"/> Termination of employment		
<input type="checkbox"/> Termination of employer contributions toward coverage	<input type="checkbox"/> Offered plan is no longer in your service area	<input type="checkbox"/> Discontinuance of other coverage		

If either of the following events occurred, you or your dependent(s) may apply within 60 days of the date of the event. Please indicate the event that applies to you and/or your dependent(s):

<input type="checkbox"/> Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)	What was the date of the Qualifying Life Event?
<input type="checkbox"/> Gain eligibility for premium payment assistance from Medicaid or the Children's Health Insurance Program (CHIP)	
	<input type="text"/> mm <input type="text"/> dd <input type="text"/> yyyy

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Visit us at BlueCrossNC.com



**BlueCross BlueShield
of North Carolina**

C. If Making a Change from Previous Enrollment

Check All That Apply:

- Name
(Legal documentation is required.)
- Address
- Other Insurance Information
- Phone Number
- Replace ID Card
- Date of Birth Correction
(Legal documentation may be required.)
- E-Mail Address
- Other _____

Remove Dependent(s):

- | | |
|--|---|
| <input type="checkbox"/> Divorce | Date of Occurrence |
| | <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> |
| <input type="checkbox"/> Dependent Age | <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> |
| <input type="checkbox"/> Death | <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> |
| <input type="checkbox"/> Other _____ | <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> |

Reinstate Coverage:

Reason: _____

Cancel Coverage:

- | | |
|---|---|
| <input type="checkbox"/> Not Eligible | Date of Occurrence |
| | <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> |
| Reason: _____ | |
| <input type="checkbox"/> Left Employment | <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> |
| <input type="checkbox"/> Subscriber Request
(Open Enrollment Only) | <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> |
| <input type="checkbox"/> Other _____ | <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> |
| Reason: _____ | |
| _____ | |

D. Benefits and Coverage Selection – Complete for Blue Cross NC Health and Dental, if Offered by Employer

MEDICAL PLAN:	<input type="checkbox"/> Blue Care® (HMO)	<input type="checkbox"/> Blue Select Plus SM (PPO)	<input type="checkbox"/> Classic Blue® (CMM)	<input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> No Medical Coverage
	<input type="checkbox"/> Blue Options 1-2-3 SM (PPO)	<input type="checkbox"/> Blue Local SM with Atrium Health*			
	<input type="checkbox"/> Blue Options HSA SM	<input type="checkbox"/> Blue Local SM with Wake Forest Baptist Health**			
	<input type="checkbox"/> Blue Options SM (PPO)	<input type="checkbox"/> Blue Value 1-2-3 SM (POS)			
	<input type="checkbox"/> Blue Select SM (PPO)	<input type="checkbox"/> Blue Value SM (POS)			

* I understand that I am enrolling in a plan with a local provider network limited to the Blue Local with Atrium Health network. I certify to understanding that in-network providers for this plan are concentrated in the following approved counties: Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Rowan, Stanly, and Union. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network, and if I visit a provider not in this plan's network, I may only receive benefits at the out-of-network level, except for emergency, urgent care, or ambulance services.

** I understand that the plan selected has a local provider network limited to the Blue Local with Wake Forest Baptist Health. I certify to understanding that in-network providers for this plan are concentrated in the following approved counties: Davidson, Davie, Forsyth, Guilford, Randolph, Stokes, Wilkes, and Yadkin. I acknowledge that not all Blue Cross NC contracted providers may be in this plan's network, and if I visit a provider not in this plan's network, I may only receive benefits at the out-of-network level, except for emergency, urgent care, or ambulance services.

I can search for a provider in the online "find a doctor" tool to determine if my provider is in my plan's network. I acknowledge that I have the right to decline my employer's coverage and enroll in different coverage outside of the coverage offered by my employer.

MEDICAL COVERAGE (if applicable): Employee Only Employee/Spouse/Domestic Partner Employee/Child(ren) Employee/Family

If your group is offering multiple plans, please enter plan name selected: _____

DENTAL PLAN: Dental No Dental Coverage

If your group is offering multiple plans, please enter plan name selected: _____

DENTAL COVERAGE (if applicable): Employee Only Employee/Child(ren) Employee/Spouse/Domestic Partner Employee/Family

BLUE 20/20SM VISION COVERAGE (if applicable): Employee Only Employee/Child(ren) Employee/Spouse/Domestic Partner Employee/Family

DECLINE MEDICAL COVERAGE: Check one only: I am rejecting Employee Coverage I am rejecting Dependent/Spouse Coverage

Declining coverage for the following reason (check one):

- Another plan offered by my employer
- COBRA or State Continuation
- An individual plan
- I and/or my dependents are not covered by any other health benefit plan
- My spouse's group coverage
- A government plan (type): _____
- Other (explain): _____

Names of any dependents rejecting coverage: _____

I understand that if I elect to apply for coverage for myself, my spouse/domestic partner, and/or my dependent child(ren) through this employer health plan at a later time, I may be delayed until the employer's open enrollment period.

Employee Name:

Important Notice of 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, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.

Signature of Primary Applicant: **X** _____ Date

Notice of Declination of Coverage must be received by Blue Cross and Blue Shield of North Carolina (Blue Cross NC) within 30 days of the date that employee is first eligible for coverage.

E. Family Information – Legal Documentation May be Required

Health	Dental	Blue 20/20 Vision	Name First, Middle Initial, Last, Suffix	Social Security Number (Required for Spouse/Domestic Partner)	Birthdate mm/dd/yyyy	Gender	Child Status (please check if applicable)
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> M <input type="checkbox"/> F	NA
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Child 1		<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Intellectually or physically disabled
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Child 2		<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Intellectually or physically disabled
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Child 3*		<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Intellectually or physically disabled

Additional Dependent form attached
Dependent children include foster, adopted or a child placed by court or administrative order.

* If you have more than three children enrolling on the Plan, complete an Additional Dependent form.

F. Other Health Insurance Information

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier		Policy Number		Policy Holder Name	
Date of Birth	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Effective Date	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group					
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child 1 <input type="checkbox"/> Child 2 <input type="checkbox"/> Child 3 <input type="checkbox"/> Additional Dependents					

Additional Health Coverage that will be in-force when this policy becomes active:

Insurance Carrier		Policy Number		Policy Holder Name	
Date of Birth	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Effective Date	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group					
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child 1 <input type="checkbox"/> Child 2 <input type="checkbox"/> Child 3 <input type="checkbox"/> Additional Dependents					

Employee Name:

If anyone covered has Medicare Coverage please complete below:

Persons covered: Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

Medicare Claim Number: Medicare C Yes No
If yes, Carrier's Name: _____

Eligible Due To: Renal Disease; First Day of Dialysis ; Where does dialysis take place? Home Center;
 Kidney Transplant? Yes No
 Disability; Is the member actively working? Yes No
 Age

Part A Effective Date: Part B Effective Date:

G. Other Dental Insurance Information

Have you or your dependents had any other dental coverage within the last 12 months (other than Blue Cross NC coverage that you are applying for today)? Yes No

See important notices regarding special enrollment information attached. Please list any dental coverage the employee and/or dependents has/had within the last 12 months (including Blue Cross NC coverage): (To receive prior dental credit against this group benefit plan, please list prior dental coverage within the last 12 months.) Blue Cross NC may request a certificate of creditable coverage for verification purposes.

Insurance Carrier Policy Number Policy Holder Name

Date of Birth Effective Date Termination Date or Expected Termination Date (If remaining active leave blank)

What kind of coverage: Individual Group

Persons covered: Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

Additional Dental Coverage that will be in-force when this policy becomes active.

Insurance Carrier Policy Number Policy Holder Name

Date of Birth Effective Date Termination Date or Expected Termination Date (If remaining active leave blank)

What kind of coverage: Individual Group

Persons covered: Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

Additional Dental Coverage that will be in-force when this policy becomes active.

Insurance Carrier Policy Number Policy Holder Name

Date of Birth Effective Date Termination Date or Expected Termination Date (If remaining active leave blank)

What kind of coverage: Individual Group

Persons covered: Employee Spouse Domestic Partner Child 1 Child 2 Child 3 Additional Dependents

H. Statement of Understanding / Legal Notices – Your Signature is Required

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross NC (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 Blue Cross NC 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, Blue Cross NC may take legal action at any time.

I understand that if I am applying for Blue Options HSA or an HSA eligible plan and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with Blue Cross NC. Blue Cross NC is not responsible or liable for administration of the HSA.

I understand that if I am applying for a medical plan paired with an HRA and my employer has established an HRA, the HRA may be administered by Blue Cross NC separately from my health insurance plan, or by a separate administrator.

Detailed information regarding my HSA/HRA will be provided by the designated 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 establishes an HSA/HRA, my employer or their designees will share certain personal information about me with these administrators to facilitate the administrator’s establishment of the HSA/HRA account. By signing this application, I authorize my employer or their designees to share pertinent information with these selected administrators 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/HRA, I agree that although Blue Cross NC’s name and marks may be included on the face of the debit card for convenience, Blue Cross NC 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.

HSA Only:

If I am applying for Blue Options HSA or an HSA eligible plan, I understand that Blue Cross NC takes 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 administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my Blue Cross NC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.

Notice of Women’s Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

For questions or to obtain more information, contact a Blue Cross NC Customer Service Representative at: **Blue Cross NC Customer Service, Blue Cross and Blue Shield of North Carolina, PO Box 2291, Durham, NC 27702, 1-877-258-3334 (toll-free)**

By signing below, I agree to the above Statement of Understanding and have read all of the Legal Notices.

Signature of Primary Applicant: X Date

mm	dd	yyy
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I. Statement of Authorization for Release of Protected Health Information – Your Signature is Required

I understand that if I refuse to sign this authorization that Blue Cross NC may refuse to enroll me or determine that I am not eligible for benefits in Blue Cross NC.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

- (i) my past, present, or future physical or mental health or condition;
- (ii) the provision of health care to me; or
- (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy benefit manager or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to Blue Cross and Blue Shield of North Carolina ("Blue Cross NC").

I further authorize Blue Cross NC to review any applications for health care coverage that I may have submitted to Blue Cross NC in the past.

I authorize Blue Cross NC to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that Blue Cross NC will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that Blue Cross NC will make every effort to safeguard my protected health information. I further understand that Blue Cross NC will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require Blue Cross NC to disclose my protected health information. I understand that Blue Cross NC may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

**Commercial Operations/IDC
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702-2291**

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

- (i) for information that Blue Cross NC already used or disclosed, relying on this authorization or
- (ii) if the authorization was obtained as a condition of coverage in Blue Cross NC and, by law, Blue Cross NC has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below.

Signature of Primary Applicant or Legal Personal Representative: X Date

mm	dd	yyyy
----	----	------

Name of Legal Personal Representative and Relationship to Primary Applicant (please print): _____ Date

mm	dd	yyyy
----	----	------

A photographic copy of this authorization shall be as valid as the original.

Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, call the Customer Service or TTY number on the back of your member ID card.

If you believe that Blue Cross NC 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:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702
Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office
Call: 919-765-1663, 1-888-291-1783 (TTY)
Fax: 919-287-5613
Email: civilrightscordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the 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:

Online: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Mail: U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C., 20201
Call: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available online at:
<http://www.hhs.gov/civil-rights/filing-a-complaint/index.html>

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. 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. If you need these services, call the Customer Service or TTY number on the back of your member ID card.

Discrimination is Against the Law

Blue Cross NC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

