DROP

Enrollment/Change Application

Completed by Group Administrator Only
Group Number (if applicable):
Life Class Designation (if applicable):

Instructions:

-
- For change requests, complete Sections **A, B** and all other applicable sections.
- [redacted]

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

A. Employee information

First Name	Middle Initial	Last Name	Suffix

Employee Birthdate (mm dd yyyy)	Employee Social Security Number	☐ Male ☐ Female	Marital Status

Address	P.O. Box (For Blue Options HSA you must also provide a street address.)	Apt. No.	City	State	Zip Code

Company Name	Occupation

Work Location	Date of Full Time Employment (mm dd yyyy)	Language Preference ☐ Spanish ☐ English ☐ Other _____

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

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.)

☐ African American/Black ☐ Asian/Asian American ☐ Choose not to report
☐ White/Caucasian ☐ Hispanic/Latino ☐ Native American/Alaskan Native ☐ Other (specify) _____

☐ ACTIVE EMPLOYEE ☐ COBRA/STATE CONTINUATION

COBRA/State Continuation Qualifying Event: ☐ Termination of Employment ☐ Reduction in Hours ☐ Death of Subscriber ☐ Divorce ☐ Over Age Dependent ☐ Medicare Eligible

What was the date of the Qualifying Event? (mm dd yyyy) Date Continuation Started (mm dd yyyy) Date Continuation Ends (mm dd yyyy)

B. If making a change from previous enrollment

Check All That Apply:

- ☐ Name
- ☐ Address
- ☐ Other Insurance Information
- ☐ Telephone
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ E-Mail Address
- ☐ Late Applicant
- ☐ Over the Guarantee Issue
- ☐ Other _____

Add Dependent(s): Date of Occurrence (mm dd yyyy)

- ☐ Marriage
- ☐ Newborn
- ☐ Adoption
- ☐ Other _____

Remove Dependent(s): Date of Occurrence (mm dd yyyy)

- ☐ Divorce
- ☐ Dependent Age
- ☐ Death
- ☐ Other _____

Reinstate Coverage:

Reason: _____

Cancel Coverage: Date of Occurrence (mm dd yyyy)

- ☐ Not Eligible
- Reason: _____
- ☐ Left Employment
- ☐ Subscriber Request
- ☐ Other
- Reason: _____

SIGNATURE: _____

DATE: _____

BlueCross BlueShield of North Carolina

[redacted]