Enrollment/Change Application

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

Instructions:

- All employees applying for medical coverage complete Sections **A**, **C**, **D**, **E**, **F**, **I** and **J**. If your group is a small employer you must complete **G** as well.
- For change requests, complete Sections **A**, **B** and all other applicable sections.
- If your group has elected USAble®1 Life products you must complete Section **H**. **For USAble Life Only** you must complete Sections **A**, **B**, **H**, **I** and **J**.
- If declining medical coverage, please complete Sections **A** and **C**.

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 Triggering Event: ☐ Termination of Employment ☐ Reduction in Hours ☐ Death of Subscriber ☐ Divorce ☐ Over Age Dependent ☐ Medicare Eligible

What was the date of the Triggering 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
- ☐ Phone Number
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ E-Mail Address
- ☐ Triggering Event (Active Employee Only)
- ☐ Over the Guarantee Issue
- ☐ Other _____

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

- ☐ Marriage
- ☐ Newborn
- ☐ Court Ordered
- ☐ 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: _____

C. Benefits and coverage selection – complete for BCBSNC health and dental, if offered by employer

MEDICAL PLAN:

- ☐ Blue Options HSA℠
- ☐ Blue Care® (HMO)
- ☐ Blue Options℠ (PPO)
- ☐ Classic Blue® (CMM)
- ☐ Blue Options 1-2-3℠
- ☐ Blue Value℠ (POS)
- ☐ Blue Select℠ (PPO)
- ☐ Blue Local℠ with Carolinas HealthCare System*
- ☐ No Medical Coverage

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

BlueCross BlueShield of North Carolina

* I understand that I am enrolling in a plan with a local provider network limited to the Blue Local Carolinas HealthCare System 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 BCBSNC 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 20/20℠ VISION COVERAGE (if applicable): ☐ Employee Only ☐ Employee/Child(ren) ☐ Employee/Spouse/Domestic Partner ☐ Employee/Family

DECLINE 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.

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.

If your employer purchased this plan on the Small Business Health Option Program (SHOP) Exchange, you may be eligible to enroll as a result of additional triggering/qualifying events. In these cases you will have a specified timeframe within which you must enroll referred to as a special enrollment period. For a full descriptive list of triggering/qualifying events, special enrollment periods, and effective dates of coverage see www.healthcare.gov.

Signature of Primary Applicant: **X** _____ Date mm dd yyyy

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

D. Family information – ONLY complete for anyone taking medical and/or dental coverage

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 for any dependent under the age of 26)
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Spouse ☐ Domestic Partner			☐ M ☐ F	
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	**Child 1**			☐ M ☐ F	☐ Foster ☐ Adopted ☐ Handicapped
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	**Child 2**			☐ M ☐ F	☐ Foster ☐ Adopted ☐ Handicapped
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	**Child 3***			☐ M ☐ F	☐ Foster ☐ Adopted ☐ Handicapped

☐ **Additional Dependent form attached**

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

Application Continued on Next Page →

Employee Name:

E. 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 mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ 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 mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Additional Dependents

If anyone covered has Medicare Coverage please complete below:

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Additional Dependents

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

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

Part A Effective Date: mm dd yyyy | Part B Effective Date: mm dd yyyy

F. Other dental insurance information

Have you or your dependents had any other dental coverage within the last 12 months (other than BCBSNC 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 BCBSNC coverage): (To receive prior dental credit against this group benefit plan, please list prior dental coverage within the last 12 months.) BCBSNC may request a certificate of creditable coverage for verification purposes.

Insurance Carrier	Policy Number	Policy Holder Name

Date of Birth mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ 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 mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ 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 mm dd yyyy | Effective Date mm dd yyyy | Termination Date or Expected Termination Date mm dd yyyy (If remaining active leave blank)

What kind of coverage: ☐ Individual ☐ Group

Persons covered: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Additional Dependents

Application Continued on Next Page →

Employee Name:

G. Health Question for Groups 1-100 Eligible Employees

Within the past 6 months, has any of the following used tobacco regularly (4 or more times a week on average) excluding religious or ceremonial uses and, if so, when was the last time tobacco was used regularly? (Applicable only to persons who are 18 years or older.)

		Date last used (mm / dd / yyyy)
Employee: _____	☐ Yes ☐ No	
Spouse/Domestic Partner: _____	☐ Yes ☐ No	
Dependent: _____	☐ Yes ☐ No	
Dependent: _____	☐ Yes ☐ No	
Dependent: _____	☐ Yes ☐ No	

H. Coverage selection for products underwritten by USAble Life, if offered by employer

USAble Life is an independent life insurance company that does not provide BCBSNC products or services. USAble Life is solely responsible for the life and disability insurance coverage below. Your non-medical group insurance program may not include all the benefits listed below. These benefits will be written by USAble Life. Ask your employer details. Employer is required to retain a copy of this form for beneficiary information.

Life/AD&D ☐ **Yes** ☐ **No**
Dependent Life ☐ **Yes** ☐ **No**
Weekly Disability ☐ **Yes** ☐ **No**
Long Term Disability ☐ **Yes** ☐ **No**
Supplemental Life/AD&D ☐ **Yes** ☐ **No** **Supplemental Life/AD&D Amount:** _____

☐ **No Benefits Selected**

Annual Salary: _____
Required if salary based plan

Complete this Section if applying for these coverages. Evidence of insurability may be required.			**Add New**	**Delete**	**Increase Exisiting**	**Decrease Exisiting**	**Total Amount of Coverage**	**Premium (Completed by Employer**
A. Voluntary Group Life:	**Employee**	☐ Yes ☐ No						
	Spouse	☐ Yes ☐ No						
	Children	☐ Yes ☐ No						
B. Voluntary AD&D:	**Employee**	☐ Yes ☐ No						
(EOI not required)	**Spouse**	☐ Yes ☐ No						
	Children	☐ Yes ☐ No						
C. Voluntary Short Term Disability (VSTD):		☐ Yes ☐ No					per week	
D. Voluntary Long Term Disability (VLTD):		☐ Yes ☐ No					per month	

Do you presently have other disability coverage? ☐ Yes ☐ No If yes, give monthly amount $_____

Do you have any existing life insurance policies or annuity contracts? ☐ Yes ☐ No

Have you or your spouse (if applying for coverage) used tobacco products in the past year?
Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

Are you actively at work on the date of this application? ☐ Yes ☐ No

PRE-EXISTING CONDITIONS

- New Voluntary Short Term Disability (VSTD) plans and benefits increases: During the first year of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage.
- New Voluntary Long Term Disability (VLTD) plans and benefit increases: During the first 2 years of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage unless you go 6 consecutive months treatment free.

Primary Beneficiary Name **(required)**		Primary Beneficiary Address **(required)**	
Relationship	Date of Birth (mm / dd / yyyy)	Social Security Number	Percent[1]
Contingent Beneficiary Name **(required)**		Contingent Beneficiary Address **(required)**	
Relationship	Date of Birth (mm / dd / yyyy)	Social Security Number	Percent[1]
Second Contingent Beneficiary Name **(required)**		Second Contingent Beneficiary Address **(required)**	
Relationship	Date of Birth (mm / dd / yyyy)	Social Security Number	Percent[1]

Application Continued on Next Page →

[1] NOTE: The primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I select any of the products listed above that I will be covered by USAble Life at the discretion of the employer group (as indicated above).
- I understand that if I am not actively at work as defined in the policy(ies) (for the products selected above) on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

Signature of Primary Applicant: **X** _____ Date mm dd yyyy

Life insurability questionnaire – complete only if you are a late applicant or applying for coverage over the guarantee issue amount

1. Employee Height:	2. Employee Weight:

	Yes	No
3. Have you used any tobacco products in the past year?	☐	☐
4. Do you have any condition for which consultation or treatment is contemplated or has been advised?	☐	☐
5. Have you been hospitalized for any reason during the past five (5) years?	☐	☐
6. Have you consulted a physician in the past one (1) year for any reason?	☐	☐

7. Have you ever been diagnosed or treated by a member of the medical profession for:

	Yes	No		Yes	No
a. Cancer, cancer related disease or benign tumor?	☐	☐	f. Emotional, nervous system, eating disorder, or mental health problems?	☐	☐
b. Disease of the heart or blood vessels, or had a stroke?	☐	☐	g. Ulcer, stomach or digestive disorder?	☐	☐
c. Kidney disease or diabetes?	☐	☐	h. Arthritis, back, bones or joint disorder?	☐	☐
d. Alcohol or drug abuse?	☐	☐	i. Bladder, urinary system or reproductive organs disorder?	☐	☐
e. Lung, asthma, liver or blood disorder?	☐	☐			

	Yes	No
8. Have you ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")?	☐	☐
9. Have you ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? If yes, list name of person(s), medications taken, medication dosage, and last two blood pressure readings.	☐	☐
10. Are you currently taking medication(s)? If yes, list name of person, medications and dosage.	☐	☐
11. Have you ever had any impairments, diseases or illnesses not covered in questions 2-8?	☐	☐

12a. Are you now pregnant?	☐ Yes	☐ No	12b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?	☐ ☐

13. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If no, give full details. ☐ ☐

14. Names, addresses, and phone numbers of the personal physicians of all applicants:

I. 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 BCBSNC and/or the life insurance carrier (USAble Life) 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 and/or the life insurance carrier 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.

I understand that if I am applying for Blue Options HSA and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with BCBSNC. BCBSNC 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 BCBSNC 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 BCBSNC's name and marks may be included on the face of the debit card for convenience, BCBSNC 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, I understand that BCBSNC 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 BCBSNC 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.

Application Continued on Next Page →

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 BCBSNC Customer Service Representative at:

BCBSNC 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 yyyy

J. Statement of authorization for release of protected health information – your signature is required

I understand that if I refuse to sign this authorization that BCBSNC and/or USAble Life may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC and/or USAble Life.

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 ("BCBSNC") and/or USAble Life.

I further authorize BCBSNC and/or USAble Life to review any applications for health care coverage that I may have submitted to BCBSNC and/or USAble Life in the past.

In signing below, I authorize my physician, medical practitioner, hospital, clinic, or other medical facility, insurance or reinsurance company, or MIB, Inc., formerly known as Medical Information Bureau, Inc., having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance. I authorize USAble Life or its reinsurers to make a brief report of my personal health information to MIB.

I authorize BCBSNC and/or USAble Life 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 BCBSNC and/or USAble Life will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that BCBSNC and/or USAble Life will make every effort to safeguard my protected health information. I further understand that BCBSNC and/or USAble Life will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require BCBSNC and/or USAble Life to disclose my protected health information. I understand that BCBSNC and/or USAble Life 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

USAble Life
PO Box 1650
Little Rock, Arkansas 72203-1650

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 BCBSNC and/or USAble Life already used or disclosed, relying on this authorization or

(ii) if the authorization was obtained as a condition of coverage in BCBSNC and/or USAble Life and, by law, BCBSNC and/or USAble Life 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.