

ENROLLMENT APPLICATION AND CHANGE FORM

Please Use Ink When Completing

NORTH CAROLINA MEDICAL SOCIETY EMPLOYEE BENEFIT PLAN

- ENROLLMENT FORM – New Members: Complete items in Sections B, C, D, E, F, and G.
- CHANGE FORM – Current Members: Check all items you wish to change under Section A. Complete Section B. Update other appropriate sections with changes.

COMPLETED BY GROUP ADMINISTRATOR ONLY	
GROUP NUMBER	
DEPT/DIV NUMBER	EFFECTIVE DATE

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

CHECK ALL THAT APPLY: <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Telephone Change <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> ID Card Request <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other Insurance Information	ADD DEPENDENT(S): <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Other	DATE OF OCCURRENCE: _____ _____ _____	<input type="checkbox"/> CANCEL CERTIFICATE	DATE OF OCCURRENCE: _____ _____	<input type="checkbox"/> CONTINUE COVERAGE: <input type="checkbox"/> State Continuation (groups under 20 employees) <input type="checkbox"/> COBRA (groups over 20 employees) Continuation Effective Date _____
			<input type="checkbox"/> CANCEL DEPENDENT(S): <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Separation <input type="checkbox"/> Age Limit <input type="checkbox"/> Death <input type="checkbox"/> Other		CONTINUATION REASON: <input type="checkbox"/> Death <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Divorce <input type="checkbox"/> Separation

B. COVERAGE ELECTION

HEALTH COVERAGE PLAN (check one): <input type="checkbox"/> Plan 1 (\$500) <input type="checkbox"/> Plan 2 (\$750) <input type="checkbox"/> Plan 3 (\$1,000) <input type="checkbox"/> Plan 4 (\$1,500) <input type="checkbox"/> Plan 5 (\$2,000) <input type="checkbox"/> HDHP Plan 1 <input type="checkbox"/> HDHP Plan 2 <input type="checkbox"/> HDHP Plan 3 <input type="checkbox"/> HRA Series 1 <input type="checkbox"/> HRA Series 2 <input type="checkbox"/> HRA Series 3 <input type="checkbox"/> HRA Series 4 <input type="checkbox"/> HRA Series 5 <small>(If selecting HDHP or HRA plan, complete and submit an HSA/HRA Addendum.)</small>	FOR INTERNAL USE ONLY PACKAGE NUMBER
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HEALTH COVERAGE TYPE (check all that apply):
 Employee Spouse Child(ren) Family **CLASS TYPE:** Physician Non-Physician

C. EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	MARITAL STATUS	SEX
DATE OF BIRTH	ADDRESS	CITY	STATE	ZIP CODE	COUNTY
HOME PHONE	DATE OF FULL-TIME EMPLOYMENT		EMPLOYER NAME AND ADDRESS	WORK LOCATION	OCCUPATION
WORK PHONE					

D. FAMILY INFORMATION (if applicable)

NAME <small>(First, Middle Initial, Last)</small>	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	CHILD STATUS	COMPLETE IF CHILD IS AGE 19 OR OVER
SPOUSE					
CHILD #1				<input type="checkbox"/> Natural <input type="checkbox"/> Foster ¹ <input type="checkbox"/> Adopted ¹ <input type="checkbox"/> Step ¹	<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Handicapped Child ¹
CHILD #2				<input type="checkbox"/> Natural <input type="checkbox"/> Foster ¹ <input type="checkbox"/> Adopted ¹ <input type="checkbox"/> Step ¹	<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Handicapped Child ¹
CHILD #3				<input type="checkbox"/> Natural <input type="checkbox"/> Foster ¹ <input type="checkbox"/> Adopted ¹ <input type="checkbox"/> Step ¹	<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Handicapped Child ¹

¹Please attach additional documentation required. If you have more than three children, please complete Section D on another application.

E. PRIOR INSURANCE INFORMATION

This section **MUST** be completed to receive credit for prior coverage and **REDUCE or ELIMINATE** any applicable waiting period before benefits become active and claims are processed.
 Have you had any Health Insurance in the last 63 days? Yes No **IF YES, complete below:**

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY		POLICY NUMBER	
POLICY HOLDER AND DATE OF BIRTH	EFFECTIVE DATE	TERMINATION DATE	<input type="checkbox"/> If currently in effect, write "CURRENT" as the TERMINATION DATE
FAMILY MEMBERS COVERED: LIST NAMES AND RELATIONSHIPS			

F. COORDINATION WITH OTHER INSURANCE COMPANIES

IF you have more than one additional policy in force, complete Section F of another application

This section **MUST** be completed if you have additional insurance in force during this new policy.
 Are any dependents covered under another plan due to divorce/separation? Yes No **IF YES TO EITHER QUESTION, complete below:**
 Will you or your covered dependents have other insurance in addition to this policy? Yes No

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY		POLICY HOLDER NAME AND DATE OF BIRTH	
POLICY HOLDER'S EMPLOYER, ADDRESS AND PHONE		POLICY HOLDER SOCIAL SECURITY NUMBER	
POLICY NUMBER	EFFECTIVE DATES OF COVERAGE From: _____ To: _____		
INDIVIDUALS COVERED	FAMILY MEMBERS COVERED BY MEDICARE		
MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO: <input type="checkbox"/> Renal Disease <input type="checkbox"/> Age <input type="checkbox"/> Disability	MEDICARE PART A EFFECTIVE DATE	MEDICARE PART B EFFECTIVE DATE

G. BENEFICIARY DESIGNATION/CHANGE Check if New Employee Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

PRIMARY BENEFICIARY(IES)
(Will receive proceeds if living at death of Employee)

NAME <i>(First, Middle Initial, Last)</i>	ADDRESS	BIRTHDATE	RELATIONSHIP	PERCENTAGE

TOTAL MUST EQUAL 100% =

CONTINGENT BENEFICIARY(IES)
(Will receive proceeds if primary beneficiary[ies] are not living)

NAME <i>(First, Middle Initial, Last)</i>	ADDRESS	BIRTHDATE	RELATIONSHIP	PERCENTAGE

TOTAL MUST EQUAL 100% =

H. DEPENDENT LIFEDependent Life Coverage Election (if offered by employer): Accept Decline**I. STATEMENT OF UNDERSTANDING AND AUTHORIZATION**

I understand that the benefits for which I (we) will be eligible are those described in the group contract and any changes provided for therein.

I understand that the NORTH CAROLINA MEDICAL SOCIETY EMPLOYEE BENEFIT PLAN ("PLAN") and/or the life insurance carrier may, within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, PLAN may take legal action at any time.

I understand that the PLAN imposes a pre-existing condition exclusion. This means that if I have a medical condition before coming to the PLAN, I might have to wait a certain period of time before the PLAN will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before my coverage becomes effective. However, if I was in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

Further, I understand that this exclusion may last up to 12 months from my first day of coverage, or, if I was in a waiting period, from the first day of my waiting period. However, I can reduce the length of this exclusion period by the number of days of my prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if I have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by my creditable coverage, I should give the PLAN a copy of any certificates of creditable coverage I have. If I do not have a certificate, but I do have prior health coverage, the PLAN will help me obtain one from my prior plan or issuer. There are also other ways that I can show I have creditable coverage.

Please contact the PLAN if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

North Carolina Medical Society Employee Benefit Plan
Attention: Customer Service
P.O. Box 97968
Raleigh, NC 27624
1-800-662-7917

I represent that the information provided herein is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I hereby designate the above beneficiaries under this certificate and revoke the appointment of any existing beneficiary. If the Group Insurance Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

WARNING: Any person who commits a fraudulent act may be guilty subject to fines and confinement in prison.

Date: _____ Signature of Employee: _____