



**North Carolina Medical Society
Employee Benefit Plan**

ENROLLMENT APPLICATION AND CHANGE FORM

Please Use Ink When Completing

COMPLETED BY GROUP ADMINISTRATOR ONLY

GROUP NUMBER	
DEPT/DIV NUMBER	EFFECTIVE DATE

- 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.

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): DATE OF OCCURRENCE: <input type="checkbox"/> Marriage _____ <input type="checkbox"/> Newborn _____ <input type="checkbox"/> Adoption _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> CANCEL CERTIFICATE DATE OF OCCURRENCE: <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 _____	CONTINUE COVERAGE: <input type="checkbox"/> State Continuation (groups under 20 employees) <input type="checkbox"/> COBRA (groups with 20 or more employees) Continuation Effective Date _____ CONTINUATION REASON: <input type="checkbox"/> Death <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Social Security Disability Determination <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Over Age Dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Separation
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B. COVERAGE ELECTION

HEALTH COVERAGE PLAN (check one) <input type="checkbox"/> PPO 500-80 <input type="checkbox"/> PPO 750-80 <input type="checkbox"/> PPO 1000-80 <input type="checkbox"/> HDHP 2700-100 <input type="checkbox"/> HDHP 2700-80 <input type="checkbox"/> PPO 1500-80 <input type="checkbox"/> PPO 2000-80 <input type="checkbox"/> PPO 2500-80 <input type="checkbox"/> HRA 2700-100 <input type="checkbox"/> HRA 2700-80	FOR INTERNAL USE ONLY PACKAGE NUMBER
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(If plan selected is to be combined with an HSA or HRA, complete and submit an HSA/HRA Addendum.)

HEALTH COVERAGE TYPE (check all that apply) <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Children <input type="checkbox"/> Family	CLASS TYPE (must indicate one) <input type="checkbox"/> Physician <input type="checkbox"/> Non-Physician
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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 (complete if selecting Spouse, Child, Children, or Family coverage in Section B)

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

(If you have more than three children, complete Section D on another application)

¹ Student status and handicapped child information required for all family members who exceed the eligible dependent age maximum.

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 NAME AND DATE OF BIRTH	EFFECTIVE DATE
TERMINATION DATE	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. Will you or your covered dependents have other insurance in addition to this policy? Yes No **IF YES TO EITHER QUESTION, complete below:**

Are any dependents covered under another plan due to divorce/separation? 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 (If your employer offers Term Life and AD&D Insurance) 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 (First, Middle Initial, Last)	ADDRESS	BIRTHDATE	RELATIONSHIP	PERCENTAGE

TOTAL MUST EQUAL 100% =**CONTINGENT BENEFICIARY(IES)**
(Will receive proceeds if primary beneficiary[ies] are not living)

NAME (First, Middle Initial, Last)	ADDRESS	BIRTHDATE	RELATIONSHIP	PERCENTAGE

TOTAL MUST EQUAL 100% =**H. DEPENDENT LIFE INSURANCE** (If your employer offers Dependent Life Insurance)Dependent Life Coverage Election: Accept Decline**I. STATEMENT OF UNDERSTANDING AND AUTHORIZATION**

You understand that the benefits for which you will be eligible are those described in the group contract and any changes provided for therein.

You 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.

You understand that the PLAN imposes a pre-existing condition exclusion for all employees and dependents whether they are timely or late enrollees. This means that if you have a medical condition before coming to the PLAN, you 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 you were 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 or foster care. Eligible children (newborns, adoptive children, foster children, and those added as a result of a court order) are not subject to this exclusion period when enrolled more than 30 days after one of the events listed above if you coverage type or the premiums owed are not affected by adding the child.

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

Throughout this notice, all references to "you" are meant to refer to both the employee and their dependents. For questions or to obtain more information, contact:

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. Term Life and AD&D Insurance and Dependent Life Insurance are underwritten by USABLE Life Insurance Company.

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

Date: _____ Signature of Employee: _____