



North Carolina Medical Society Employee Benefit Plan  
 P.O. Box 97968 Raleigh, NC 27624  
 Fax: 919-878-7590



**ENROLLMENT FORM FOR GROUP INSURANCE**  
**SECTION TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)**

Name of Employee Last First Middle			Social Security No.	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Employee's Address Street			City State Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Employee's E-mail Address			Phone No. (include area code)		
Name of Employer			Customer Number <b>TS 05621973</b>	Division	Class
Employer's Street Address			City	State	Zip Code Employee Work Location
Date of Hire (Mo./Day/Yr.)	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Employee's Occupation		Coverage Effective Date (Mo./Day/Yr.)	
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence					Hours Worked Per Week
<input type="checkbox"/> Original COBRA Effective Date (Mo./Day/Yr.) _____					
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Change in Enrollment <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____					
<b>COVERAGE REQUEST DATA:</b> I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below. I request the following coverage: <b>Employee Coverage</b> <input type="checkbox"/> Dental <b>Dependent Spouse Coverage</b> (Note: Dependent coverage is provided under the same plan the employee has chosen.) <input type="checkbox"/> Dental <b>Dependent Child Coverage</b> (Note: Dependent coverage is provided under the same plan the employee has chosen.) <input type="checkbox"/> Dental <input type="checkbox"/> I wish to <b>DECLINE</b> any coverage not checked above for which I may be eligible. For Dental and/or Dependent Dental Coverage, a waiting period may be required before I and/or a dependent can be enrolled. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____					
<b>If applying for Dependent coverage (Spouse and Child), complete section below:</b> Number of dependents (including spouse) Name (Last, First, MI) Date of Birth Sex (M/F) Spouse: _____ Child(ren): _____			If dependent children are full-time students in college, vocational or trade school, please complete the following: Child(ren) Name of School _____ _____ _____		

