



North Carolina Medical Society
Employee Benefit Plan

ENROLLMENT APPLICATION AND CHANGE FORM

Please Use Ink When Completing

- 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 <input type="checkbox"/> Address <input type="checkbox"/> Telephone <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> Replace ID Card <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Late Applicant <input type="checkbox"/> Other Insurance Information	ADD DEPENDENT(S): DATE OF OCCURENCE <input type="checkbox"/> Marriage _____ <input type="checkbox"/> Newborn _____ <input type="checkbox"/> Adoption _____ <input type="checkbox"/> Other _____	REMOVE DEPENDENT(S): DATE OF OCCURENCE <input type="checkbox"/> Marriage _____ <input type="checkbox"/> Divorce _____ <input type="checkbox"/> Dependent Age _____ <input type="checkbox"/> Death _____ <input type="checkbox"/> Other _____	CANCEL COVERAGE: DATE OF OCCURENCE <input type="checkbox"/> Not Eligible _____ <input type="checkbox"/> Left Employment _____ <input type="checkbox"/> Subscriber Request _____ <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 of Subscriber <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Over Age Dependent <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Divorce
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B. COVERAGE ELECTION

HEALTH COVERAGE PLAN (check one)	PPO <input type="checkbox"/> 500-80 <input type="checkbox"/> 750-80 <input type="checkbox"/> 1000-80 <input type="checkbox"/> 1500-80 <input type="checkbox"/> 2000-80 <input type="checkbox"/> 2500-60 <input type="checkbox"/> 3500-80 <input type="checkbox"/> 5000-60	FOR INTERNAL USE ONLY PACKAGE NUMBER
	PPO 1-2-3 <input type="checkbox"/> 1000 <input type="checkbox"/> 1500 <input type="checkbox"/> 2000 <input type="checkbox"/> 2500 <input type="checkbox"/> 3500	
	HDHP <input type="checkbox"/> 1500-100 <input type="checkbox"/> 2700-80 <input type="checkbox"/> 2700-100 <input type="checkbox"/> 3500-100 <input type="checkbox"/> 5000-100 HRA <input type="checkbox"/> 2500-100 <input type="checkbox"/> 2700-80 <input type="checkbox"/> 2700-100 <input type="checkbox"/> 5000-100	

(If plan selected is to be combined with a Mellon/ACS HSA or a BCBSNC 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
DATE OF FULL-TIME EMPLOYMENT	EMPLOYER NAME AND ADDRESS	WORK LOCATION	OCCUPATION	HOME PHONE	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)
SPOUSE				
CHILD #1				<input type="checkbox"/> Foster <input type="checkbox"/> Adopted
CHILD #2				<input type="checkbox"/> Foster <input type="checkbox"/> Adopted
CHILD #3				<input type="checkbox"/> Foster <input type="checkbox"/> Adopted

(If you have more than three children, 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		
POLICYHOLDER 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. Are any dependents covered under another plan due to divorce/separation? Yes No Will you or your covered dependents have other insurance in addition to this policy? Yes No **IF YES TO EITHER QUESTION, complete below:**

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY	POLICYHOLDER NAME AND DATE OF BIRTH		
POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE	POLICYHOLDER 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 and replace 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.

If you are declining enrollment for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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 women receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses and; 4) Treatment of physical complications of the mastectomy, including lymph edemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information on WHCRA benefits, call your Plan Administrator.

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: _____