

ENROLLMENT FORM

(Please print in ink)



PO Box 24042
Winston-Salem, NC 27114-4042
(336) 774-4400 Fax: (336) 760-3028
1-800-795-1023
eligibilityreferrals@medcost.com

EMPLOYEE INFORMATION

Company Name				Group Number			
Employees Last Name		First Name		Middle Initial		Date of Birth	
Address		City		State		Zip	
County		Sex ☐ Male ☐ Female		Social Security Number		Home Phone	
Street Address		City		State		Zip	
Are you actively at work? ☐ Yes ☐ No		Hours worked per week		Position/Job Title			
Date of Full Time Employment		Date of Hire		Current Income \$ ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Salaried			

COVERAGE ELECTED AS OFFERED BY PLAN

MEDICAL ☐ Myself	☐ Dependent(s) Coverage	PLAN OPTION _____
DENTAL ☐ Myself	☐ Dependent(s) Coverage	PLAN OPTION _____
VISION ☐ Myself	☐ Dependent(s) Coverage	PLAN OPTION _____
☐ Short Term Disability ☐ Long Term Disability ☐ Life/Add ☐ Dependent Life ☐ Supplemental Life \$ _____		
Beneficiaries for Life Insurance Primary _____ Relationship _____		
Secondary _____ Relationship _____		

OTHER HEALTH INSURANCE COVERAGE

Do you or your dependents have other health insurance coverage, including Cobra, Medicare, or Medicaid? ☐ Yes ☐ No

Name of Insurance Company _____ Name of Policy Holder _____

Relationship to Employee _____ Plan/Policy Number _____

DEPENDENT INFORMATION

					CHECK ALL THAT APPLY			
First/Middle/Last	Birthdate	SS Number	Sex	Relationship	Medical	Vision	Dental	Disabled*

*If dependent is disabled and over age 26, please submit proof of disability.

AUTHORIZATION AND CERTIFICATION

I hereby apply for insurance and/or self-funded benefits and understand that if I am not actively at work for the required number of hours according to the plan document at the time my application is approved, the coverage is not effective until the date this requirement is met. The beneficiary designation supersedes all previous designations. I agree the copy of my signature or copy of this form may be accepted as my signature.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my family's health, to give to the insurer including its reinsurers, such information. A photographic copy of this authorization shall be as valid as the original.

I agree that, to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage by any underwriter or carrier. Subject to the approval of this application the benefits applied for shall become effective in accordance with the terms of this plan document.

I understand that benefits, once offered and refused, may be elected at a later date only by my completing a health questionnaire and meeting certain eligibility requirements.

Employee Signature

Date

TO BE COMPLETED BY EMPLOYER

This section must be completed in order to be processed.

I certify the information to be complete and accurate to the best of my knowledge.

Effective Date of Coverage _____

Authorized Signature

Date

INSTRUCTIONS FOR EMPLOYER

1. Please check form before mailing. **ALL** items must be completed according to your Trust Agreement with the Municipal Insurance Trust of North Carolina.
2. If applicable, Certification of Dependent Eligibility form must be attached to enrollment card.
Failure to comply will result in unnecessary delay of employee enrollment process.
3. If enrollment is late, all past due premiums must be paid in full within thirty (30) days before employee can be placed on insurance plan.

If you have any questions please contact MedCost at 1-800-795-1023.

Submit completed form immediately with appropriate documentation to:

MedCost Benefit Services
PO Box 24042
Winston-Salem, NC 27114
Fax: (336) 760-3028
Email: eligibilityreferrals@medcost.com