CHANGE FORM
(Please print in ink)

NCLM HEALTH BENEFITS | MEDCOST® BENEFIT SERVICES d/b/a MBS Third Party Administrators in California

1-888-230-6873
eligibilityreferrals@medcost.com

EMPLOYEE INFORMATION

Company Name			Group Number
Employees Last Name	First Name	Middle Initial	Date of Birth
Sex ☐ Male ☐ Female	Social Security Number		Home Phone

REASON FOR ADDITION

Effective Date: _____ ☐ Newborn ☐ Marriage ☐ Adoption/Custodial Date_____ ☐ Other_____

Check the coverage you wish to ADD

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_____

REASON FOR CANCELLATION

Last Date of Employment: _____ Effective Date of Termination:_____
☐ Termination of Employment ☐ Leave/Payoff ☐ Retiring Benefits ☐ Working less than 20 hours per week
☐ Divorce/Separation Date:_____ ☐ Other_____(must specify reason if other)

Check the coverage you wish to CANCEL

MEDICAL ☐ Myself ☐ Dependent(s) Coverage
DENTAL ☐ Myself ☐ Dependent(s) Coverage
VISION ☐ Myself ☐ Dependent(s) Coverage

☐ Short Term Disability ☐ Dependent Life
☐ Long Term Disability ☐ Supplemental Life $_____
☐ Life/Add

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.

CHANGES IN COVERAGE STATUS

Indicate changes to current coverages below

Basic Life ☐ Employee
Changes in active employee status to ☐ General Employee ☐ Department Head ☐ Top Administrator
Changes from current status to retiree ☐ Employee ☐ Spouse ☐ Child(ren)
Changes from current status to Medicare Supplement* ☐ Employee ☐ Spouse

*Copy of Medicare card required to change status to Medicare Supplement. If retiring with partial benefits, indicate coverage terminated on front of card.

Employee Current Annual Salary: _____ Effective Date of Change:_____
Department Change ☐ Yes ☐ No If yes, name of new department:_____

OTHER CHANGES

Effective date of change_____

☐ Change of address _____ City_____State_____Zip_____
☐ Name change From _____ To_____
☐ Location Change From_____ To_____
☐ Beneficiary Change Name _____ Relationship to insured_____
☐ Other _____

TO BE COMPLETED BY EMPLOYEE

Employee's signature is required for all changes and terminations except termination of employment.

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 summary plan description of your employer's health care plan.

Signature of Employee_____ 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.

_____ _____
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 1-888-230-6873.

Submit completed form immediately with appropriate documentation to:

Email: eligibilityreferrals@medcost.com