ENROLLMENT 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
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 1-888-230-6873.

Submit completed form immediately with appropriate documentation to:

Email: eligibilityreferrals@medcost.com