

COUNTY HEALTH PLAN

ENROLLMENT AND CHANGE APPLICATION

Change Request: For changes, complete sections A, B, F and all other applicable sections.

COMPLETED BY GROUP ADMINISTRATOR ONLY

Effective Date _____

Member Group Name _____

Dept/Division/Class _____

New enrollees should indicate New Enrollment below and complete the entire form.

PLEASE TYPE OR PRINT IN INK.

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT (CHECK ALL THAT APPLY)

<input type="checkbox"/> New Enrollment	Add Dependent(s)	Date	Remove Dependent(s)	Date	COBRA Qualifying Event:
<input type="checkbox"/> Name/Address Change	<input type="checkbox"/> Marriage		<input type="checkbox"/> Marriage		<input type="checkbox"/> Termination of Employment
<input type="checkbox"/> Replace ID Card	<input type="checkbox"/> Newborn		<input type="checkbox"/> Divorce		<input type="checkbox"/> Reduction in Hours
<input type="checkbox"/> Date of Birth Correction	<input type="checkbox"/> Adoption		<input type="checkbox"/> Loss of Status		<input type="checkbox"/> Divorce
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Full-time Student		<input type="checkbox"/> Death		<input type="checkbox"/> Separation
<input type="checkbox"/> Other Insurance Information	<input type="checkbox"/> Loss of Other Coverage		<input type="checkbox"/> Other		<input type="checkbox"/> Medicare Eligible
<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Other _____				<input type="checkbox"/> Social Security Disability Determination
<input type="checkbox"/> Return from Leave					<input type="checkbox"/> Military Leave/Leave (Other)

B. EMPLOYEE INFORMATION

<input type="checkbox"/> Active Employee	<input type="checkbox"/> COBRA	Date COBRA Continuation Started		Date Continuation Ends	
First Name/Middle Initial	Last Name	Employee SSN		Home Phone Number	Work Phone Number
Address		<input type="checkbox"/> Female <input type="checkbox"/> Male	Employee Birth Date	E-mail Address	
City	County	State & Zip		Marital Status	
Job Position		Date of Full-time Employment		Work Location	

C. YOUR COVERAGE SELECTIONS - Complete for Health and Dental (if offered)

Please speak to HR for their definition of High/Low plans. Select your coverage.	<input type="checkbox"/> HMO <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> PPO <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> CMM	<input type="checkbox"/> Dental <input type="checkbox"/> High <input type="checkbox"/> Low
Select a Medical Tier	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Family <input type="checkbox"/> Waive Medical
Select a Dental Tier	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Family <input type="checkbox"/> Waive Dental

D. FAMILY INFORMATION - Complete for anyone taking Medical and/or Dental coverage

- List family members **TAKING** medical or dental.
- Student Status and Handicapped Child information required for all family members who exceed the eligible dependent age maximum.

Name (First, Middle, Last)	Social Security Number	Birth Date	Sex	Health	Dental	If child is 19 or older, indicate status and school they are attending.
SPOUSE			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CHILD 1			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-time Student at:
CHILD 2			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-time Student at:
CHILD 3			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Handicapped <input type="checkbox"/> Full-time Student at:

If you have more than three children you wish to cover, please complete Section D on another application and attach.

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION

E1. PRIOR HEALTH INSURANCE:

This section **MUST** be completed in full to receive credit for prior coverage and **REDUCE** or **ELIMINATE** any applicable waiting period. Please do not submit copy of previous ID card.

Have you had any Health Insurance within the last 63 days? Yes No If YES, complete below

Name and Address of Health Insurance Company	Policy Number	Insurance Company Phone Number
Policyholder and Date of Birth _____ / _____ / _____	Effective Date _____ / _____ / _____	Termination Date _____ / _____ / _____ If other coverage will remain in effect write N/A in term box and complete section below

Family Members Covered: List Names and Relationships

Have you or your dependents been a previous NCACC covered Member? Dates and ID Number

E2. OTHER HEALTH INSURANCE: *This section **MUST** be completed in full if you will have additional insurance in force during this new policy.*

Will you or your covered dependents have other insurance in addition to this policy? YES NO

Are any dependents covered under another plan due to divorce/separation? 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	<input type="checkbox"/> If individual coverage check here	Policyholder's 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	Part A Effective Date _____ / _____ / _____	Part B Effective Date _____ / _____ / _____

F. STATEMENT OF UNDERSTANDING AND AUTHORIZATION

I authorize any medical professional, medical care institution, or other provider of health care services or supplies to furnish to the plan information concerning services or supplies provided to me or any family member. I understand that this information will be used for the purposes of determining eligibility for coverage, review, investigation, or payment of a claim and review of records for quality improvement initiatives. Such records may be reviewed by third party quality review organizations. I authorize any prior insurance carrier to furnish information concerning me and/or my dependents' prior insurance coverage provided. The authorization is valid for 30 months from the date of this signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with review of claims.

I understand that the plan 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, the plan may take legal action at any time.

I understand that personal information may be collected from persons other than me or my dependents, and personal and privileged information collected by the plan may, in certain circumstances, be disclosed to others without my authorization. I understand that I have the right to access and correct any defects in information collected, and that I may obtain a more detailed explanation of this notice upon request.

I understand that in the course of its business operations the plan obtains personal information about me and my dependents, and uses this information for the administration of the plan(s). I further understand that in certain situations this information may need to be disclosed to others, including contractors working on behalf of the carrier. I hereby consent to these disclosures as permitted or required by law and as set forth in the HIPAA regulations. In particular, I consent to disclosures by the plan in connection with treatment, payment, health care operations as authorized by law, coordination of care, quality assessment and measurement and accreditation. I also consent to disclosures authorized by the North Carolina Insurance Information Privacy act (the "Act"), including but not limited to those that are reasonably necessary to allow the performance of business, professional, or insurance functions on behalf of the Plan(s), those made to detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction, those made to insurance regulatory authorities, and those made in response to an administrative or judicial order, or a subpoena. I further recognize that there are certain disclosures for which the law does not require my consent, and that these disclosures may be made by the plan as permitted or required by law.

I also consent to disclosures of information to my employer, in connection with their administration of the employee health benefits plan.

I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.

Employee Signature _____ Date _____