

# 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

Employer Name		Date of Full-Time Employment (mm/dd/yyyy)	
Group Plan Number	Location/Division	Department/Plant	
<input type="checkbox"/> Hourly Employee <input type="checkbox"/> Salaried Employee	Plan Option	Social Security Number	
Employee Name Last First Middle Initial		Birth Date (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		City	State Zip
Email Address		Primary Phone Number ( ) area code	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Hours worked per week	Position/Job Title

## COVERAGE ELECTED

**MEDICAL**  Single  Employee & Spouse/Partner  Employee + 1 Child  Employee + Children  Family

## DEPENDENT INFORMATION

To be completed for all dependents (if any) to be covered under this policy.

Full Name First/Middle/Last	Birthdate (mm/dd/yyyy)	Dependent SSN	Sex	Relationship	Other Coverage
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

## OTHER MEDICAL OR DENTAL COVERAGE

If other coverage (including COBRA, Medicare, or Medicaid) is still in effect, complete the information below.

Name of Insurance Company \_\_\_\_\_ Name of Policyholder \_\_\_\_\_

Relationship to Employee \_\_\_\_\_ Plan/Policy # \_\_\_\_\_ Effective Date \_\_\_\_\_  
(mm/dd/yyyy)

Have you or any of the dependents you are enrolling for medical coverage under this plan been covered by another plan within 63 days before your hire date with this company?  Yes  No

If yes, attach a Certificate of Creditable Coverage for each person who was covered by another plan.

## AUTHORIZATION AND CERTIFICATION FORM

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. 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 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 my employer's health plan document.

I understand that benefits, once refused, may not be elected at a later date unless certain eligibility requirements are met.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date