



MedCost Benefit Services
 P.O. Box 24042
 Winston-Salem, NC 27114-4042
 (336) 774-4400 Fax (336) 760-3028
 1-800-795-1023

MEDCOST BENEFIT SERVICES USE ONLY

PLAN NO.	EFFECTIVE DATE	CLASS
LOCATION NO.	BENEFIT PACKAGE	TIER CODE
PROCESSED DATE	USER ID	

ENROLLMENT FORM

PLEASE PRINT IN INK OR TYPE

Company Name						Division	
Employee Last Name		First Name		Middle Initial	Birth Date / /	Sex M F	Social Security Number
Street Address			City	State	Zip	County	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Home Phone	Are you Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hours Worked Per Week	Position / Job Title	Date of Full time employment	

COVERAGE ELECTED AS OFFERED BY PLAN

- I WISH TO ELECT COVERAGE AS OFFERED BY PLAN FOR MYSELF
- I WISH TO ELECT COVERAGE AS OFFERED BY PLAN FOR MY DEPENDENT(S)
- LONG TERM DISABILITY
- SUPPLEMENTAL LIFE # _____

DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH INSURANCE COVERAGE, INCLUDING COBRA, MEDICARE OR MEDICAID?

Yes No If yes, complete this section:

Name of Insurance Company: _____

Name of Policyholder: _____

Relationship to Employee: _____ Plan/Policy #: _____

APPLICANT'S CURRENT INCOME

\$ _____ Week Month Year
 Hourly Salaried

BENEFICIARIES FOR LIFE INSURANCE:

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

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

First	MI	Last Name	Birthdate			SS Number	Sex	Relationship	Full-Time Student (Y or N)	D
			Mo.	Day	Yr.					

*PROOF OF FULL-TIME STUDENT STATUS REQUIRED. ATTACH COPY OF PAID TUITION RECEIPT, CURRENT SEMESTER SCHEDULE, OR SCHOOL CERTIFICATION LETTER.

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 cover 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.

SIGNATURE OF EMPLOYEE _____ DATE SIGNED _____