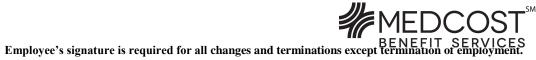


(Please print in ink)



PO Box 24042 Winston-Salem, NC 27114-4042 (336) 774-4400 Fax: (336) 760-3028 1-800-795-1023

EMPLOYEE INFORMATION									
Company Name				Group Number					
Employees Last Name		First Name			Middle Initial Date of Birth				
Social Security Number									
REASON FOR ADDITION									
Effective Date									
□ Newborn □ Marriage □ Loss		Adoption/Custodia	al Date _		• Othe	er			
Check the coverage you wish to AD)D								
☐ Medical for myself Plan Option _		☐ Vision for mysel	f Plan O	ption	_ Life/A	Add			
☐ Medical for my dependent(s)		☐ Vision for my dependent(s)			Dependent Life				
☐ Dental for myself Plan Option		☐ Short-term disability			☐ Supplemental Life \$				
☐ Dental for my dependent(s)		☐ Long-term disability							
REASON FOR CANCELLATION									
Last Day of Employment		Effective Da	ite of Ter	mination			-		
☐ Termination of Employment ☐ I	Leave/Layoff 🗖	Death Retiring	Benefits	☐ Turned 19 and	not a student	☐ Workin	g less than 2	0 hrs per week	
☐ Divorce/Separation Date		Other			(you must	specify rea	son if other)		
Check the coverage you wish to CA	NCEL_								
☐ Medical for myself		☐ Short-term disabi	lity		☐ Life/A	dd			
• •	☐ Medical for my dependent(s)				☐ Dependent Life				
☐ Dental for myself	☐ Vision for myself	· · · · · · · · · · · · · · · · · · ·			☐ Supplemental Life \$				
☐ Dental for my dependent(s)		☐ Vision for my dep	pendent(s)	☐ All coverage offered by plan					
DEPENDENT INFORMATION									
					CH	ECK ALL	THAT API	PLY	
	Birthdate								
First / Last / Middle	mo/day/yr	SS Number	Sex	Relationship	Medical	Vision	Dental	Disabled*	
*If child is disable and over age 26		proof of disability.							
CHANGES IN COVERAGE STATU	JS								
Indicate desired changes to curre	<u>ent coverages be</u>								
Basic Life		□ Employee							
				☐ Department Head ☐ Top Administrator					
Changes from current status to retiree \square Employee \square Spouse \square Child(ren)									
Changes from current status to M				☐ Spouse					
*Copy of Medicare card required to	-	= =				-		f card.	
Employee Current Annual Salary				_					
Department Change Yes N	lo If yes, name	e of new departmen	t						
OTHER CHANGES									
Effective date of change									
_				GY.		~			
☐ Change of address									
□ Name change from									
☐ Location change									
☐ Beneficiary change				Kelationship to	insured				
∟ı Umer									



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 must be completed in order to be processed.		
I certify the above information to be complete and accurate to the best of	f my knowledge.	
Authorized Signature	Date	

INSTRUCTION

If you have any questions please contact MedCost at 1-800-795-1023

Mail change card immediately with appropriate documentation to:

MedCost Benefit Services PO Box 24042 Winston-Salem, NC 27114