ENROLLMENT FORM

(Please print in ink)

MedCost®
BENEFIT SERVICES
d/b/a MBS Third Party Administrators in California

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

EMPLOYEE INFORMATION

Company Name __________Vance County Government______________________________________ Group Number ______________________

Employees Last Name _________________________ First Name ________________________ Middle Initial _______ Date of Birth ___________

Street Address ____ City __________________ St _____ Zip ___________ County _______________

Sex ________ Social Security Number _____________________________ Home Phone ___________________________

Are you actively at work? ❑ Yes ❑ No Hours worked per week _______ Position/Job Title ____

Date of Full Time Employment _____________________ Date of Hire

COVERAGE ELECTED AS OFFERED BY PLAN

❑ Medical for myself |
Plan Option PPO ______HDHP_______
❑ Medical for my dependent(s)
❑ Dental for myself
❑ Dental for my dependent(s)

❑ Vision for myself | Plan Option _________
❑ Vision for my dependent(s)
❑ Short-term disability
❑ Long-term disability

❑ Life/Add
❑ Dependent Life
❑ Supplemental Life $_________

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 ____

Applicant's Current Income $_____________________ ❑ Hourly ❑ Week ❑ Month ❑ Year ❑ Salaried

Beneficiaries for Life Insurance Primary _______________________________________ Relationship _____________________________________

Secondary _____________________________________ Relationship _____________________________________

DEPENDENT INFORMATION

					CHECK ALL THAT APPLY			
First / Last / Middle	**Birthdate mo/day/yr**	**SS Number**	**Sex**	**Relationship**	**Medical**	**Vision**	**Dental**	**Disabled***

*If child is disable and over age 26, please submit proof of disability.

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.

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 my knowledge.

Effective Date of Coverage ___________________________________

Authorized Signature ____ Date __________________________

INSTRUCTION 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 and/or Student Status 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 1-800-795-1023.

Mail change card immediately with appropriate documentation to:

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