FirstCarolinaCare INSURANCE COMPANY

42 Memorial Drive ♦ Pinehurst, NC 28374 ♦ (800) 574-8556

ENROLLMENT & CHANGE FORM

TYPE OF COVERAGE REQUESTED (CHECK ONE)
○ SINGLE ○ EMPLOYEE + SPOUSE ○ EMPLOYEE + CHILD(REN) ○ FAMILY

REASON FOR COMPLETING THIS FORM (CHECK ONE)
○ INITIAL ELIGIBILITY (WITHIN 31 DAYS) ○ SPECIAL ENROLLMENT PERIOD ○ CHANGE IN STATUS ○ OTHER

REASON FOR CHANGE (MUST BE WITHIN 31 DAYS OF EVENT) DATE OF EVENT: ____/____/_____ (MM/DD/YYYY) *ATTACH DOCUMENTATION
○ MARRIAGE* ○ DIVORCE/LEGAL SEPARATION* ○ DEPENDENT ELIGIBILITY ○ BIRTH/ADOPTION* ○ CHANGE OF HOURS ○ DEATH
○ COBRA EXHAUSTED ○ LOSS OF OTHER COVERAGE ○ SPOUSE GROUP COVERAGE BEGAN ○ OTHER GROUP COVERAGE CHANGE* ○ OTHER

EMPLOYER NAME **HIRE DATE** (MM/DD/YYYY) / /

EMPLOYEE NAME LAST FIRST MI **STATUS** (CHECK ONE) ○ SINGLE ○ MARRIED **EMAIL ADDRESS**

MAILING ADDRESS **CITY** **STATE** **ZIP CODE** **COUNTY** **HOME PHONE** ( ) - **WORK PHONE** ( ) -

COMPLETE THE FOLLOWING SECTION FOR YOURSELF AND COVERED DEPENDENTS

SELF ○ ADD ○ DROP	**LAST NAME**	**FIRST**	**MI**	**SEX** ○ MALE ○ FEMALE	**OPTIONAL QUESTIONS – FOR STATISTICAL PURPOSES ONLY** What is your racial/ethnic designation? ○ White ○ African American ○ Asian ○ Native American ○ Latino/Hispanic ○ Other	**PLAN USE ONLY**
DATE OF BIRTH MONTH DAY YEAR		**SSN**			Have you been without coverage for the past year? ○ Yes ○ No	
SPOUSE ○ ADD ○ DROP	**LAST NAME**	**FIRST**	**MI**	**SEX** ○ MALE ○ FEMALE	What is your racial/ethnic designation? ○ White ○ African American ○ Asian ○ Native American ○ Latino/Hispanic ○ Other	
DATE OF BIRTH MONTH DAY YEAR		**SSN**			Have you been without coverage for the past year? ○ Yes ○ No	
DEP 1 ○ ADD ○ DROP	**LAST NAME**	**FIRST**	**MI**	**SEX** ○ MALE ○ FEMALE	What is your racial/ethnic designation? ○ White ○ African American ○ Asian ○ Native American ○ Latino/Hispanic ○ Other	
DATE OF BIRTH MONTH DAY YEAR ○ CHILD ○ STEPCHILD ○ OTHER		**SSN**			Have you been without coverage for the past year? ○ Yes ○ No	
DEP 2 ○ ADD ○ DROP	**LAST NAME**	**FIRST**	**MI**	**SEX** ○ MALE ○ FEMALE	What is your racial/ethnic designation? ○ White ○ African American ○ Asian ○ Native American ○ Latino/Hispanic ○ Other	
DATE OF BIRTH MONTH DAY YEAR ○ CHILD ○ STEPCHILD ○ OTHER		**SSN**			Have you been without coverage for the past year? ○ Yes ○ No	
DEP 3 ○ ADD ○ DROP	**LAST NAME**	**FIRST**	**MI**	**SEX** ○ MALE ○ FEMALE	What is your racial/ethnic designation? ○ White ○ African American ○ Asian ○ Native American ○ Latino/Hispanic ○ Other	
DATE OF BIRTH MONTH DAY YEAR ○ CHILD ○ STEPCHILD ○ OTHER		**SSN**			Have you been without coverage for the past year? ○ Yes ○ No	

List name(s) of any dependent children who are physically or mentally disabled: _____

Are you or any of your dependents eligible for Medicare? o Yes o No Part A Effective Date: ___/___/_____ Part B Effective Date: ___/___/_____ Part D Effective Date: ___/___/_____

If Yes, Indicate Name(s) and Medicare HICN from ID Card: _____

Do you or any of your dependents have other group health coverage? o Yes o No IF YES, IS COVERAGE o SINGLE o EMPLOYEE/SPOUSE o EMPLOYEE/CHILD o FAMILY

NAME OF INSURANCE CARRIER(S) _____ POLICY# _____ EFFECTIVE COVERAGE DATE ____/____/____ TERMINATION DATE ____/____/_____

POLICYHOLDER NAME_____ POLICYHOLDER DATE OF BIRTH _____/_____/_____ FAMILY MEMBERS COVERED _____

Is any dependent covered or eligible for coverage as an employee under an employer-sponsored health plan? If yes, please provide details: _____

I apply for enrollment for the persons listed, and agree that I and my family shall be covered according to the terms of the applicable plan. I hereby authorize deductions from my earnings of any required contribution. For purposes of administration of this coverage, I hereby authorize FirstCarolinaCare Insurance Company to release or obtain necessary medical records or claim information from any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or insurance company. A photographic copy of this authorization shall be as valid as the original. To the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true, and I agree that they will be the basis of enrollment. I will notify FCC promptly in writing concerning any changes in the above information. This authorization will be valid for the later of twelve (12) months from the date this authorization is signed, or the term of coverage of this policy.

EMPLOYEE SIGNATURE: _____ DATE ____/____/____

FOR EMPLOYER/OFFICE USE ONLY: GROUP # _____ DEPARTMENT # _____ EFFECTIVE DATE: _____ SUBSIDY ELIGIBLE _____