Group Enrollment Card

NC League of Municipalities Risk Management Services — Health Benefits Trust

1. Employer _____ **2.** Organization ID# 90 _____

SECTION I **EMPLOYEE PERSONAL DATA**

3. Name (LAST, FIRST, MI) _____ **4.** Social Security # _____

5. Mailing Address (STREET, CITY, STATE, ZIP) _____

_____

6. Date Of Birth _____ **7.** Gender ❒ MALE ❒ FEMALE **8.** Marital Status ❒ MARRIED ❒ DIVORCED ❒ SINGLE ❒ SEPARATED ❒ WIDOWED

SECTION II **EMPLOYMENT DATA**

9. Date Employed _____ **10.** Job Title _____ **11.** Annual Wages $ _____

12. Job Class. ❒ TOP ADMINISTRATOR ❒ DEPT. HEAD ❒ GENERAL EMPLOYEE ❒ OTHER ❒ ELECTED OFFICIAL **13.** ❒ Retiree

SECTION III **COVERAGE DATA**

14. Indicate Desired Coverages Below

Please review to assure that these coverages are offered by your specific government unit.

DENTAL	BASIC LIFE	MEDICAL	VISION	SHORT-TERM DISABILITY	LONG-TERM DISABILITY	SUPPLEMENTAL LIFE*
❒ EMPLOYEE	❒ EMPLOYEE	❒ EMPLOYEE	❒ EMPLOYEE	❒ YES	❒ YES	AMOUNT $ _____
❒ SPOUSE	❒ DEPENDENT	❒ SPOUSE	❒ SPOUSE	❒ NO	❒ NO	❒ DECLINE
❒ CHILD(REN)		❒ CHILD(REN)	❒ CHILD(REN)			

List Covered Dependents: *(Attach additional pages if necessary)*
Certificate of Dependent Eligibility form for dependents with last names different than the employee must be attached to this enrollment card.
If a dependent child is 19 years or older, a Student Status form must be attached to this enrollment.

	SSN	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH	DISABLED*
SPOUSE							
CHILD							❒
CHILD							❒
CHILD							❒
CHILD							❒

**If child is disabled and over age 19, please submit proof of disability.*

SECTION IV **LIFE INSURANCE BENEFICIARY**

15. **Beneficiary Name _____ **16.** Relationship _____ **17.** Date of Birth _____

(INDICATE FULL NAME OF BENEFICIARY, I.E. MARY E. DOE, MRS. JOHN DOE)

*Named beneficiary applies to basic life and supplemental life unless otherwise indicated. **Unless otherwise specified, surviving beneficiaries will share equally. If there is no designated beneficiary living on the death of the employee, payment will be made to the estate of the employee.

SECTION V **CREDITABLE COVERAGE DATA**

Do you or your dependents have previous creditable medical coverage under another health plan such as an employer sponsored group health plan or HMO, individual policy, Medicare, Medicaid, or Champus? ❒ YES ❒ NO

If yes, a copy of any certificates may be required prior to any claims being processed under this plan. ❒ CERTIFICATE ATTACHED ❒ CERTIFICATE BEING FORWARDED

SECTION VI **OTHER INSURANCE**

Are you, your spouse or dependent(s) covered by Medicare or any other Health Insurance? ❒ Yes ❒ No If yes, please complete the following:

Spouse's or Dependent's Employer _____ Employer's Phone No _____

Effective Date _____ Name of Health Insurance Co. _____

Policy #Names of individual covered by other insurance _____

❒ I hereby request coverage under the group policy(ies) issued by my employer's health plan covering certain employees of my employer and authorize my employer to deduct from my earnings any required contributions. I am an eligible employee working the required hours per week for my employer.

❒ Or, I hereby waive the following coverages offered to me. ❒ medical ❒ dental ❒ vision ❒ other _____ Proof of other coverage must be provided.

18. Employee Signature _____ **19.** Date _____

MUST BE COMPLETED BY THE EMPLOYER IN ORDER TO BE PROCESSED

I Certify the above information to be complete and accurate to the best of my knowledge

20. Effective Date of Coverage _____ **21.** Authorized Signature: _____ **22.** Date _____

10-8-09

INSTRUCTIONS:

Employer:

1. Please check form before mailing. Items **No. 1 through No. 23 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.

Call NCLM Risk Management Services at 800/228-0986 if you have any questions.

MAIL ENROLLMENT CARD IMMEDIATELY WITH APPROPRIATE DOCUMENTATION TO:

Municipal Insurance Trust of NC
Post Office Box 1310
Raleigh, North Carolina 27602

If you need to add an employee to your bill, please refer to your Administrative Manual.

HIPAA

RMS Use Only

1. Name _____ Creditable Coverage _____ Days

   Pre-X Start Date _____ End Date _____

2. Name _____ Creditable Coverage _____ Days

   Pre-X Start Date _____ End Date _____

3. Name _____ Creditable Coverage _____ Days

   Pre-X Start Date _____ End Date _____

4. Name _____ Creditable Coverage _____ Days

   Pre-X Start Date _____ End Date _____

DENTAL LIMITATIONS

1. Name _____ End Date _____
2. Name _____ End Date _____
3. Name _____ End Date _____
4. Name _____ End Date _____

IDENTIFY DISABLED DEPENDENTS

Name _____ Date of Birth _____

NOTES