

TYPE OF COVERAGE REQUESTED (CHECK COVERAGE TYPE AND TIER)		<input type="radio"/> MEDICAL <input type="radio"/> SINGLE <input type="radio"/> EMPLOYEE + SPOUSE <input type="radio"/> EMPLOYEE + CHILD(REN) <input type="radio"/> FAMILY <input type="radio"/> DENTAL <input type="radio"/> SINGLE <input type="radio"/> EMPLOYEE + SPOUSE <input type="radio"/> EMPLOYEE + CHILD(REN) <input type="radio"/> FAMILY			REASON FOR COMPLETING THIS FORM (CHECK ONE)								
		<input type="radio"/> INITIAL ELIGIBILITY (WITHIN 31 DAYS) <input type="radio"/> SPECIAL ENROLLMENT <input type="radio"/> OTHER <input type="radio"/> CHANGE IN STATUS											
REASON FOR CHANGE (MUST BE WITHIN 31 DAYS OF EVENT)		DATE OF EVENT: ____/____/____ (MM/DD/YYYY)		*ATTACH DOCUMENTATION									
<input type="radio"/> MARRIAGE* <input type="radio"/> DIVORCE/LEGAL SEPARATION* <input type="radio"/> COBRA EXHAUSTED <input type="radio"/> LOSS OF OTHER COVERAGE		<input type="radio"/> DEPENDENT ELIGIBILITY <input type="radio"/> BIRTH/ADOPTION* <input type="radio"/> SPOUSE GROUP COVERAGE BEGAN <input type="radio"/> OTHER GROUP COVERAGE CHANGE*		<input type="radio"/> CHANGE OF HOURS <input type="radio"/> DEATH <input type="radio"/> OTHER									
EMPLOYER NAME					HIRE DATE (MM/DD/YYYY)								
EMPLOYEE NAME LAST		FIRST		MI		STATUS (CHECK ONE)		EMAIL ADDRESS					
						<input type="radio"/> SINGLE <input type="radio"/> MARRIED							
MAILING ADDRESS			CITY		STATE		ZIP CODE		COUNTY				
									HOME PHONE				
									() - () -				
									WORK PHONE				
									() - () -				
COMPLETE THE FOLLOWING SECTION FOR YOURSELF AND COVERED DEPENDENTS													
SELF <input type="radio"/> ADD <input type="radio"/> DROP	LAST NAME			FIRST		MI		SEX (M or F)		OPTIONAL QUESTIONS – FOR STATISTICAL PURPOSES ONLY			PLAN USE ONLY
										What is your racial/ethnic designation? <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Asian <input type="radio"/> Native American <input type="radio"/> Latino/Hispanic <input type="radio"/> Other			
DATE OF BIRTH MM/DD/YYYY						SSN			Have you been without coverage for the past year? <input type="radio"/> Yes <input type="radio"/> No				
SPOUSE <input type="radio"/> ADD <input type="radio"/> DROP	LAST NAME			FIRST		MI		SEX (M or F)		OPTIONAL QUESTIONS – FOR STATISTICAL PURPOSES ONLY			PLAN USE ONLY
										What is your racial/ethnic designation? <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Asian <input type="radio"/> Native American <input type="radio"/> Latino/Hispanic <input type="radio"/> Other			
DATE OF BIRTH MM/DD/YYYY						SSN			Have you been without coverage for the past year? <input type="radio"/> Yes <input type="radio"/> No				
DEP 1 <input type="radio"/> ADD <input type="radio"/> DROP	LAST NAME			FIRST		MI		SEX (M or F)		OPTIONAL QUESTIONS – FOR STATISTICAL PURPOSES ONLY			PLAN USE ONLY
										What is your racial/ethnic designation? <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Asian <input type="radio"/> Native American <input type="radio"/> Latino/Hispanic <input type="radio"/> Other			
DATE OF BIRTH MM/DD/YYYY						SSN			Have you been without coverage for the past year? <input type="radio"/> Yes <input type="radio"/> No				
DEP 2 <input type="radio"/> ADD <input type="radio"/> DROP	LAST NAME			FIRST		MI		SEX (M or F)		OPTIONAL QUESTIONS – FOR STATISTICAL PURPOSES ONLY			PLAN USE ONLY
										What is your racial/ethnic designation? <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Asian <input type="radio"/> Native American <input type="radio"/> Latino/Hispanic <input type="radio"/> Other			
DATE OF BIRTH MM/DD/YYYY						SSN			Have you been without coverage for the past year? <input type="radio"/> Yes <input type="radio"/> No				
DEP 3 <input type="radio"/> ADD <input type="radio"/> DROP	LAST NAME			FIRST		MI		SEX (M or F)		OPTIONAL QUESTIONS – FOR STATISTICAL PURPOSES ONLY			PLAN USE ONLY
										What is your racial/ethnic designation? <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Asian <input type="radio"/> Native American <input type="radio"/> Latino/Hispanic <input type="radio"/> Other			
DATE OF BIRTH MM/DD/YYYY						SSN			Have you been without coverage for the past year? <input type="radio"/> Yes <input type="radio"/> No				

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

Are you or any of your dependents eligible for Medicare? Yes 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? Yes No IF YES, IS COVERAGE SINGLE EMPLOYEE/SPOUSE EMPLOYEE/CHILD 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 ____/____/____