

V. Change of Personal Information
See the Sample Forms – Exhibits 18 & 19

A. Procedure to change information using the [Enrollment Form](#):

- Select “Other” for Reason Completing the Form
- Select Reason if available as a choice; also write in Change of address and/or name in blank after “Other”
- Fill out employee information on the top section of the form
- Sign and date form

B. Procedure to change information using [Name, Address & Telephone Change Form](#):

- Fill out all sections of the form, including the name of the employer
- Be sure to have the employee sign and date the form.

SECTION V
EXHIBITS

TYPE OF COVERAGE REQUESTED (Circle)		SINGLE	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD	FAMILY
REASONS FOR COMPLETING THIS FORM: (Circle)		INITIAL ELIGIBILITY (WITHIN 31 DAYS)		SPECIAL ENROLLMENT PERIOD	CHANGE IN STATUS <u>(OTHER)</u>
CHANGE DUE TO QUALIFYING EVENT (Must be within 31 days of event) (Circle)					
<u>MARRIAGE</u>		DIVORCE/LEGAL SEPARATION	DEPENDENT ELIGIBILITY	BIRTH/ADOPTION	CHANGE OF HOURS
COBRA EXHAUSTED		LOSS OF OTHER COVERAGE	SPOUSE'S GROUP COVERAGE BEGAN	OTHER GROUP COVERAGE CHANGE	DEATH
EMPLOYER NAME		ABC COMPANY		HIRE DATE	01/01/02
EMPLOYEE NAME		JONES SALLY (SMITH)		SS#	123-45-6789
MAILING ADDRESS		12 MAPLE ST		CITY	ANYTOWN
				STATE	NC
				ZIP	20000
				COUNTY	MOORE
SELF		FIRST		OPTIONAL QUESTIONS FOR STATISTICAL REPORTING PURPOSES ONLY	
<input type="checkbox"/> ADD				What is your racial/ethnic designation?	
<input type="checkbox"/> DROP				<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian	
Date of Birth		Month Day Year		<input type="checkbox"/> Native American <input type="checkbox"/> Latino / Hispanic <input type="checkbox"/> Other	
				Were you uninsured for at least 6 months in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SPOUSE				What is your racial/ethnic designation?	
<input type="checkbox"/> ADD				<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian	
<input type="checkbox"/> DROP				<input type="checkbox"/> Native American <input type="checkbox"/> Latino / Hispanic <input type="checkbox"/> Other	
Date of Birth		Month Day Year		Were you uninsured for at least 6 months in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DEP 1				What is your racial/ethnic designation?	
<input type="checkbox"/> ADD				<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian	
<input type="checkbox"/> DROP				<input type="checkbox"/> Native American <input type="checkbox"/> Latino / Hispanic <input type="checkbox"/> Other	
Date of Birth		Month Day Year <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		Were you uninsured for at least 6 months in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DEP 2				What is your racial/ethnic designation?	
<input type="checkbox"/> ADD				<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian	
<input type="checkbox"/> DROP				<input type="checkbox"/> Native American <input type="checkbox"/> Latino / Hispanic <input type="checkbox"/> Other	
Date of Birth		Month Day Year <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		Were you uninsured for at least 6 months in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DEP 3				What is your racial/ethnic designation?	
<input type="checkbox"/> ADD				<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian	
<input type="checkbox"/> DROP				<input type="checkbox"/> Native American <input type="checkbox"/> Latino / Hispanic <input type="checkbox"/> Other	
Date of Birth		Month Day Year <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other		Were you uninsured for at least 6 months in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List name(s) of any dependent children who are physically or mentally disabled:					
If dependent children are age 19 or older, do they attend school on a full-time basis? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, PLEASE COMPLETE THE FOLLOWING (verification from institution required to complete enrollment):					
CHILD'S NAME: _____ INSTITUTION _____					
Are you or any of your dependents eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No PART A <input type="checkbox"/> EFFECTIVE DATE ____/____/____ PART B <input type="checkbox"/> EFFECTIVE DATE ____/____/____					
IF YES, NAMES: _____					
Do you or any of your dependents have other group health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, IS COVERAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> EMPLOYEE/CHILD <input type="checkbox"/> FAMILY					
NAME OF INSURANCE CARRIER(S) _____ POLICY# _____ EFFECTIVE COVERAGE DATE ____/____/____ TERMINATION DATE ____/____/____					
POLICYHOLDER NAME _____ POLICYHOLDER DATE OF BIRTH ____/____/____ FAMILY MEMBERS COVERED _____					
I apply for FirstCarolinaCare enrollment for the persons listed, and agree that I and my family shall be covered according to the terms of the Plan. I hereby authorize deductions from my earnings of any required contribution. For purposes of administration of this health coverage, I hereby authorize FirstCarolinaCare 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 the issuance of my coverage. I will notify FirstCarolinaCare 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: <u>Sally Jones</u> DATE <u>05/15/04</u>					
FOR EMPLOYER/OFFICE USE ONLY GROUP# _____ DEPARTMENT # _____ EFFECTIVE DATE <u>05/10/04</u>					

SECTION V
Name/Address Change

Exhibit 18

97-173-5

SECTION V

FirstCarolinaCare, Inc.
Name, Address & Telephone Number Change Form

Group Name: ABC COMPANY

Date: 05-15-04 Member SS #: 123-45-6789

Member Name: MARY JONES

Former Name (if applicable): MARY SMITH

New Mailing Address 12 MAPLE ST.

City ANYTOWN State: NC Zip: 20000 County MOORE

Telephone #: 910-215-1234

Employee
Signature: Mary Jones

Miscellaneous
information: Married 05-10-04