Group Name

Preferred Health Plan of the Carolinas

GROUP NUMBER:

MEDICAL: Circle One **Employee Only** **Employee + Spouse** **Employee + Child(ren)** **Family**

DENTAL: Circle One **Employee Only** **Employee + Spouse** **Employee + Child(ren)** **Family**

Employee Social Security Number	Employee Last Name	First Name	M.I.	Date of Birth (Mo/Day/Year)	Sex

Street Address	City, State	Zip Code	Home Phone # ( )	Work Phone # ( )

Email Address

Employer Name		Location	Network (Medical Only)

DEPENDENTS TO BE COVERED

LIST SPOUSE AND/OR ELIGIBLE DEPENDENTS TO BE COVERED. USE SEPARATE FORM FOR ADDITIONAL INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)	**DATE OF BIRTH** (MO/DAY/YEAR)	**SOCIAL SECURITY NUMBER**	**SEX**	OTHER INS. COV. (LIST DETAILS BELOW)
Spouse				**Y / N**
2.				**Y / N**
NAME OF CHILDREN (LAST, FIRST, MIDDLE INITIAL)	**DATE OF BIRTH** (MO/DAY/YEAR)	**DEPENDENT SOCIAL SECURITY NUMBER**	**SEX**	OTHER INS. COV. (LIST DETAILS BELOW)
3.				**Y / N**
4.				**Y / N**
5.				**Y / N**
6.				**Y / N**
7.				**Y / N**

Do pre-existing conditions exist on any family member?
☐ YES ☐ NO

If yes, describe: (include member's name and diagnosis/condition)
_____
_____

Is your spouse employed? YES NO Place of Employment: _____ Phone #: _____

If yes, please complete Other Insurance Coverage Section.

OTHER INSURANCE COVERAGE	After coverage becomes effective under this Plan will you or any family member be enrolled in any other health insurance plan? SINGLE FAMILY	Name of Policyholder

Employer or Group Sponsor	Claim Administrator or Insurance Company Name	Plan Number

☐ **I DO NOT WISH TO ELECT COVERAGE AT THIS TIME**. If checked, indicate **ONE** of the statements below:
- ☐ I have coverage through my spouse's health plan.
- ☐ I have coverage through COBRA Continuation which expires _____ (Month) _____ (Year)
- ☐ I DO NOT have other health plan coverage and understand I am not permitted to enroll as a Special Enrollee in the future.

Employee Signature for Waiver _____ Date _____

I Have Read and Agreed To The Authorization On The Bottom Of This Form.	**Applicant's Signature**	Date

Employment Verification By		Employment Date	Date Waiting Period Began	Effective Date of Coverage

ENROLLMENT FORM AUTHORIZATION

In the event that this Application for Coverage is accepted, I authorize any physician or other provider of health services to give to Preferred Health Plan, upon request, any information concerning the health condition or treatment of any person included under such coverage whenever such information is considered necessary by the Plan for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed on Preferred Health Plan by state of federal statutes.

In the event that a third party may cause injury or illness to myself or any dependents listed. I hereby agree to reimburse Preferred Health Plan for any amounts I may receive by way of a settlement for health services received.
All information furnished in this application is true, correct, and complete to the best of my knowledge.