



# Preferred Health Plan of the Carolinas

## HYBRID PLAN

**MEDICAL: 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 (REQUIRED)					
Employer Name					Insurance Company

### 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 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

**Is your spouse employed?**    YES    NO    Place of Employment: \_\_\_\_\_    Phone #: \_\_\_\_\_

If yes, please complete Other Insurance Coverage Section.

<b>OTHER INSURANCE COVERAGE</b>	After coverage becomes effective under this Plan will you or any family member be enrolled in any other health insurance plan?	Name of Policyholder
	SINGLE                  FAMILY	
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.	<b>Applicant's Signature</b>	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 of the Carolinas, 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 of the Carolinas by state or 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 of the Carolinas 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.