

Administered by:



CORPORATE BENEFIT SERVICES OF AMERICA, INC. Your Strategic Benefits Partner 400 HWY 169 South, Ste. 800 Minneapolis, MN 55426-1141

Insurance Underwritten by: North Carolina Mutual Life Insurance Company Durham, North Carolina

# Employee Application for Insurance

This Section to be Completed by Your Employer	_____			
	Group Name	Group Number	Division Number	Class

**1. REASON FOR APPLICATION**

New Coverage

Change in Coverage: Requested Effective Date of Change \_\_\_\_\_

Add  Delete Coverage for (name) \_\_\_\_\_

Other (Please describe) \_\_\_\_\_

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Enrolling for Coverage that I Previously Waived/Declined (Please check reason at right)

COBRA Coverage Exhausted  Newborn  Adoption

Spouse's Employer No Longer Contributes to Premium  Marriage

Lost Coverage Through Spouse Date of Event \_\_\_\_\_

**2. INFORMATION ABOUT YOU** Email Address \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Social Security Number \_\_\_\_\_ Occupation \_\_\_\_\_  Male  Female

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

*Last First Middle Initial*

Address \_\_\_\_\_ ( ) \_\_\_\_\_

*Number & Street City County State Zip Home Phone*

Spouse Address (if different) \_\_\_\_\_ ( ) \_\_\_\_\_

*Work Phone*

Marital Status:  Single  Married; date of marriage \_\_\_\_\_  Separated; date separated \_\_\_\_\_

Divorced; date of divorce \_\_\_\_\_  Widowed; date widowed \_\_\_\_\_

Hours Worked per Week \_\_\_\_\_ Date Hired/Rehired (circle one) to full-time \_\_\_\_\_ Monthly Earnings\$ \_\_\_\_\_

Are you currently covered by Worker's Compensation?  Yes  No

Is your spouse currently covered by Workers' Compensation Insurance?  Yes  No Spouse's Occupation \_\_\_\_\_

**3. INFORMATION ABOUT YOUR DEPENDENTS** (complete Section 8 if waiving dependent coverage)

PLEASE PRINT NAME OF DEPENDENTS APPLYING FOR COVERAGE	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT	IF CHILD AGE 19 TO 25 INDICATE IF FULL TIME COLLEGE STUDENT	DATE OF BIRTH MO./DAY/YEAR	HEIGHT	WEIGHT
			<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		

**4. COVERAGE OPTIONS**

Please check the coverage(s) you're applying for below. Availability of coverage(s) is based on your employer's selected plan of insurance.

Employee	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Disability	<input type="checkbox"/> Life	<b>Designate Beneficiary if Electing Life Insurance:</b> Name of Beneficiary _____ Relationship _____
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child (ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**FOR HOME OFFICE USE ONLY**

<input type="checkbox"/> New <input type="checkbox"/> Late	<input type="checkbox"/> Previously Insured _____	<input type="checkbox"/> APS attached (confidential) on _____
<input type="checkbox"/> Timely	<input type="checkbox"/> Employee <input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Questionnaire attached on _____
<input type="checkbox"/> Special	<input type="checkbox"/> Spouse <input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> PVS attached
<input type="checkbox"/> 24 Hr. Cov. + look.date _____	<input type="checkbox"/> Children <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Effective Date _____

## 5. OTHER COVERAGE INFORMATION

This information you provide about other coverage ( either prior or current) is necessary to determine whether you will have any waiting periods for pre-existing conditions. It will also help us to coordinate benefits with any other group health plan you may have. To ensure proper credit towards the pre-existing clause of the policy, attach a Certificate of Creditable Coverage.

1. Have you or your dependents had health insurance coverage with another carrier ( s) at anytime during the last 12 months?  
 Yes  No If yes, answer the following:

**\*\*Provide information ( below) about all the health insurance coverage you have had during the previous 12 months\*\***

Name of Policyholder \_\_\_\_\_ SS# of Policyholder \_\_\_\_\_

Effective date of policy \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Termination date of policy \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*mo day year mo day year*

Reason coverage ended: \_\_\_\_\_

Type of Plan: Group  Individual  Other Persons covered:  Self  Spouse  Child/ren

Name of insurance company \_\_\_\_\_ Telephone number \_\_\_\_\_

Was this a group policy offered through an employer?  Yes  No If yes, provide the following:

Name of employer \_\_\_\_\_ Telephone number ( ) \_\_\_\_\_

2. Will you or your dependents continue to be covered under another health insurance plan while you are covered under this North Carolina Mutual Life Insurance Company plan?  Yes  No If yes, answer the following:

Who will continue to be covered:  Self  Spouse  Child/ren

Effective date of policy \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Type of plan:  Group  Individual  Other  
*mo day year*

Name of insurance company \_\_\_\_\_ Telephone number ( ) \_\_\_\_\_

Is this plan through your spouse's employer?  Yes  No If yes, provide the following:

Name of employer \_\_\_\_\_ Telephone number ( ) \_\_\_\_\_

3. Do you or your dependents currently have Medicare coverage?  Yes  No If yes, answer the following:

Name of person covered by Medicare \_\_\_\_\_ Medicare claim number \_\_\_\_\_

Is Medicare eligibility due to?  Over age 65  End-stage renal disease  Total disability

Part A effective date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Part B effective date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*mo day year mo day year*

4. Are you or your dependents currently insured by North Carolina Mutual Life Ins. Co.?  Yes  No

Were you or your dependents previously insured by North Carolina Mutual Life Ins. Co.?  Yes  No

## 6. HEALTH INFORMATION - Answer All Questions

1. Has anyone named in this application taken any medications prescribed by a physician during the past year?  Yes  No  
If yes, complete the following. If additional space is needed, attach a separate sheet of paper.

NAME OF MEDICATION	DOSAGE	CURRENTLY TAKING	DATE LAST TAKEN
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

2. Within the last 10 years, has anyone named in this application been seen, treated, counseled, or taken medication for:

- |  |   |   |
|--|---|---|
| <p><b>Yes No</b></p> <p>a. <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p>b. <input type="checkbox"/> <input type="checkbox"/> Heart Disease or Disorder</p> <p>c. <input type="checkbox"/> <input type="checkbox"/> Stroke, Clot or Circulatory Disorder</p> <p>d. <input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p>e. <input type="checkbox"/> <input type="checkbox"/> Allergies, Asthma or Sinus Disorder</p> <p>f. <input type="checkbox"/> <input type="checkbox"/> Emphysema, Respiratory or Lung Disease or Disorder</p> <p>g. <input type="checkbox"/> <input type="checkbox"/> Cancer or malignant growth</p> <p>h. <input type="checkbox"/> <input type="checkbox"/> Hepatitis, Cirrhosis or other Liver Disease or Disorder</p> <p>i. <input type="checkbox"/> <input type="checkbox"/> Ulcers, Stomach, Esophagus, Intestinal, Rectal or Colon Disease or Disorder</p> <p>j. <input type="checkbox"/> <input type="checkbox"/> Transplant of any kind</p> <p>k. <input type="checkbox"/> <input type="checkbox"/> Obesity or Gastric Bypass</p> <p>l. <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia or Chronic Fatigue Syndrome</p> <p>m. <input type="checkbox"/> <input type="checkbox"/> Benign tumor or benign growth</p> | <p><b>Yes No</b></p> <p>n. <input type="checkbox"/> <input type="checkbox"/> Back, Spine, Joint or Muscle Disease or Disorder</p> <p>o. <input type="checkbox"/> <input type="checkbox"/> Migraine or Headache</p> <p>p. <input type="checkbox"/> <input type="checkbox"/> Depression, Anxiety, Bipolar or other Psychological Disorder</p> <p>q. <input type="checkbox"/> <input type="checkbox"/> Attention Deficit ( ADD or ADHD or Behavioral Disorder</p> <p>r. <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis</p> <p>s. <input type="checkbox"/> <input type="checkbox"/> Arthritis, Lupus, Scleroderma, Connective Tissue Disease or Disorder</p> <p>t. <input type="checkbox"/> <input type="checkbox"/> Epilepsy, Seizure or Neurological Disorder</p> <p>u. <input type="checkbox"/> <input type="checkbox"/> Thyroid, Adrenal or Pituitary Disease or Disorder</p> <p>v. <input type="checkbox"/> <input type="checkbox"/> Ear, Eye or Skin Disease or Disorder</p> <p>w. <input type="checkbox"/> <input type="checkbox"/> Acquired Immune Deficiency Syndrome ( AIDS) or AIDS Related Complex ( ARC)</p> | <p><b>Yes No</b></p> <p>x. <input type="checkbox"/> <input type="checkbox"/> Menstrual or Gynecological Disorder</p> <p>y. <input type="checkbox"/> <input type="checkbox"/> Infertility</p> <p>z. <input type="checkbox"/> <input type="checkbox"/> Kidney, Bladder or Prostate Disease or Disorder</p> <p>aa. <input type="checkbox"/> <input type="checkbox"/> Anemia, Blood or Lymph Node Disease or Disorder</p> <p>bb. <input type="checkbox"/> <input type="checkbox"/> Alcohol, Drug or Chemical Abuse</p> <p>cc. <input type="checkbox"/> <input type="checkbox"/> Any other condition, disease, disorder or treatment</p> <p>dd. <input type="checkbox"/> <input type="checkbox"/> Has anyone named in this application been advised of the possibility for future testing, surgery or hospitalization</p> <p>ee. <input type="checkbox"/> <input type="checkbox"/> Is anyone named in this application currently pregnant. Due date _____</p> <p>ff. <input type="checkbox"/> <input type="checkbox"/> Is anyone named in this application currently disabled or unable to perform normal work or age related activities. Date of Disability _____</p> |
|--|---|---|

3. In the spaces below, provide full details to questions for which you answered "Yes" above. If additional space is needed, attach a separate sheet of paper.

QUESTION NO. & LETTER	FAMILY MEMBER	DATES OF TREATMENT	DATE OF FULL RECOVERY	LIST THE CONDITION AND TYPE OF TREATMENT RECEIVED	NAME/PHONE NUMBER OF PHYSICIAN/HOSPITAL

## 7. DISCLOSURES, AUTHORIZATION AND SIGNATURE

The Insurer, in performing its obligations under the Policy, is acting as a fiduciary as prescribed by ERISA. The Administrator, in performing its obligations under the Policy, is acting as a fiduciary as prescribed by ERISA and under the terms and conditions of the Administrative Services Agreement between the Insurer and the Administrator. The medical policy excludes coverage for health care services relating to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within six months prior to your enrollment date. This waiting period for pre-existing conditions complies with state and federal law and will not exceed a period of 12 months from your enrollment date if you enroll when you're initially eligible or during a special enrollment period, or a period of 18 months if you're a late enrollee. The policy's waiting period for pre-existing conditions will be shortened if you had prior qualifying coverage and had no lapse in coverage of 63 days or more (not including probationary periods). Prior qualifying coverage may be demonstrated by providing the Administrator with a Certificate of Creditable Coverage from your prior plan or health insurance carrier. If you don't have a Certificate of Creditable Coverage, contact your prior plan or carrier. Federal law requires your prior plan to provide you with such a Certificate if you send them a written request within 24 months of the date your coverage ended. If you aren't able to obtain a Certificate of Creditable Coverage after requesting one in writing, the Administrator will assist you in obtaining the necessary information to demonstrate prior qualifying coverage. If applicable, I authorize my employer to make deductions from my earnings for my share of the cost of the coverage to which I am entitled. I understand and agree that no coverage shall be in force until: the Administrator approves this application, eligibility requirements have been met, and a certificate of insurance is issued, which shall not be valid unless the first period cost is paid. I further understand that this application will become a part of the Master Policy. I also understand that any misstatements or failure to provide sought for information may be used as the basis for denying a claim. I understand that any intent to defraud or knowingly facilitate a fraud against the North Carolina Mutual Life Insurance Company by submitting an application for filing a claim containing a false or deceptive statement is insurance fraud. I certify that I have read the statements on this form or that they have been read to me, and that all the information was provided by me and is true and complete. I further understand that no agent can modify this application, waive the answers to any question, or suggest or complete the answers hereto.

Signature of Applicant \_\_\_\_\_ Date Signed \_\_\_\_\_

## 8. WAIVER OF INSURANCE

If you wish to waive coverage for yourself and/or your dependents, please complete this section and sign below.

Employee Name \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

### #1 Employee's Refusal of:

Group Medical Insurance

Dental Insurance

Life Insurance

for:  myself  my spouse  my child/ren

### #2 Reason for Refusal:

Insured under spouse's plan

Insured under another plan

Contribution required

Other ( list explanation)

I hereby certify that I have been given an opportunity to apply for insurance under the Group Insurance policy or policies provided by my employer, and that I have declined to do so of my own accord. I certify that I was not induced or pressured by my employer, the insurance agent or the insurance company into declining coverage.

I understand that by not applying for such insurance, I will not become insured under said policy or policies and will not be entitled to any benefits thereunder.

I further understand that if I and/or my dependents desire to apply for such insurance at a later date, coverage may possibly not be available or I may be required to provide health status information for purposes of group rate setting. Depending on applicable law, coverage may possibly not be issued or penalties such as deferred effective dates or pre-existing limitations may be imposed.

Signature of Applicant \_\_\_\_\_ Date Signed \_\_\_\_\_

## NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents are waiving medical coverage, the following special enrollment periods may be available.

- If you and/or your eligible dependents ( including your spouse) initially decline enrollment under this plan because of coverage under another group health plan and later you or your dependents lose eligibility for that other health plan ( this includes COBRA coverage) , then you and/or your eligible dependents may be able to enroll in this plan within 30 days of the other coverage ending.
- If you and/or your eligible dependents ( including your spouse) initially decline enrollment under this plan because of coverage under another group health plan and later you or your dependents lose the employer contribution for that other plan, then you and/or your eligible dependents may be able to enroll in this plan within 30 days of the loss of the employer contribution for the other coverage.
- If you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or being a party in a suit for adoption, you may be able to enroll yourself and your new dependents provided that you request enrollment within 30 days after the event.

Failure to specify that you are declining coverage because you have other coverage may waive your special enrollment rights as described above.