

CHANGE FORM
(Please print in ink)



PO Box 24042
Winston-Salem, NC 27114-4042
(336) 774-4400 Fax: (336) 760-3028
1-800-795-1023
eligibilityreferrals@medcost.com

EMPLOYEE INFORMATION

Company Name			Group Number		
Employees Last Name		First Name		Middle Initial	Date of Birth
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number			Home Phone	

REASON FOR ADDITION

Effective Date: _____ Newborn Marriage Adoption/Custodial Date _____ Other _____

Check the coverage you wish to ADD

MEDICAL Myself Dependent(s) Coverage PLAN OPTION _____

DENTAL Myself Dependent(s) Coverage PLAN OPTION _____

VISION Myself Dependent(s) Coverage PLAN OPTION _____

Short Term Disability Long Term Disability Life/Add Dependent Life Supplemental Life \$ _____

Beneficiaries for Life Insurance Primary _____ Relationship _____
Secondary _____ Relationship _____

REASON FOR CANCELLATION

Last Date of Employment: _____ Effective Date of Termination: _____

Termination of Employment Leave/Payoff Retiring Benefits Working less than 20 hours per week

Divorce/Separation Date: _____ Other _____ (must specify reason if other)

Check the coverage you wish to CANCEL

MEDICAL Myself Dependent(s) Coverage Short Term Disability Dependent Life

DENTAL Myself Dependent(s) Coverage Long Term Disability Supplemental Life \$ _____

VISION Myself Dependent(s) Coverage Life/Add

DEPENDENT INFORMATION

First/Middle/Last	Birthdate	SS Number	Sex	Relationship	CHECK ALL THAT APPLY			
					Medical	Vision	Dental	Disabled*

*If dependent is disabled and over age 26, please submit proof of disability.

CHANGES IN COVERAGE STATUS

Indicate changes to current coverages below

Basic Life Employee

Changes in active employee status to General Employee Department Head Top Administrator

Changes from current status to retiree Employee Spouse Child(ren)

Changes from current status to Medicare Supplement* Employee Spouse

*Copy of Medicare card required to change status to Medicare Supplement. If retiring with partial benefits, indicate coverage terminated on front of card.

Employee Current Annual Salary: _____ Effective Date of Change: _____

Department Change Yes No If yes, name of new department: _____

OTHER CHANGES

Effective date of change _____

- Change of address _____ City _____ State _____ Zip _____
- Name change From _____ To _____
- Location Change From _____ To _____
- Beneficiary Change Name _____ Relationship to insured _____
- Other _____

TO BE COMPLETED BY EMPLOYEE

Employee's signature is required for all changes and terminations except termination of employment.

I agree that to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage by any underwriter or carrier. Subject to the approval of this application the benefits applied for shall become effective in accordance with the summary plan description of your employer's health care plan.

Signature of Employee _____ Date _____

TO BE COMPLETED BY EMPLOYER

This section must be completed in order to be processed.

I certify the information to be complete and accurate to the best of my knowledge.

Authorized Signature

Date

INSTRUCTIONS FOR EMPLOYER

1. Please check form before mailing. **ALL** items must be completed according to your Trust Agreement with the Municipal Insurance Trust of North Carolina.
2. If applicable, Certification of Dependent Eligibility form must be attached to enrollment card.
Failure to comply will result in unnecessary delay of employee enrollment process.
3. If enrollment is late, all past due premiums must be paid in full within thirty (30) days before employee can be placed on insurance plan.

If you have any questions please contact MedCost at 1-800-795-1023.

Submit completed form immediately with appropriate documentation to:

MedCost Benefit Services
 PO Box 24042
 Winston-Salem, NC 27114
 Fax: (336) 760-3028
 Email: eligibilityreferrals@medcost.com