ENROLLMENT FORM
(Please print in ink)

MEDCOST® BENEFIT SERVICES
d/b/a MBS Third Party Administrators in California

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

Employer Name | Date of Full-Time Employment 1/1/2021

Group Plan Number | Location/Division | Department/Plant

☐ Hourly Employee ☐ Salaried Employee | Plan Option | Social Security Number

Employee Full Name Last First Middle Initial | Birth Date (mm/dd/yyyy) | Sex ☐ Male ☐ Female

Home Address | City | State | Zip

Email Address | Primary Phone Number (area code)

Marital Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed

Are you actively at work? ☐ Yes ☐ No | Hours worked per week | Position/Job Title

COVERAGE ELECTED
(Check all that apply.)

☐ I wish to elect coverage as offered by plan for myself
☐ I wish to elect coverage as offered by plan for dependent(s)
☐ Long Term Disability
☐ Supplemental Life

Applicant's Current Income $ ________________________ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Salary

Beneficiaries for Life Insurance Primary____________________________________ Relationship_______________________________
Secondary____________________________________ Relationship_______________________________

DEPENDENT INFORMATION

To be completed for all dependents (if any) to be covered under this policy.

Full Name First/Middle/Last	Birthdate (mm/dd/yyyy)	Dependent SSN	Sex	Relationship	Other Coverage
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

*Proof of full-time student status required for dependent children over the age of 19 for some dental groups. Attach a copy of paid tuition receipt and current semester schedule certificate letter (if applicable).

OTHER MEDICAL OR DENTAL COVERAGE

If other coverage (including COBRA, Medicare, or Medicaid) is still in effect, complete the information below.
Policyholder: Name_____________________________________ DOB__________________ Relation to Employee__________________________________

Employer Name____________________________________ Insurance Company Name___________________________ Phone________________________

Effective Date_________________ Plan/Policy # _______________________________ Type of Coverage (circle): Medical Dental Vision
Type of Plan: ☐ Employer Health Plan ☐ Retiree Plan ☐ COBRA ☐ Individual Policy ☐ Medicare*
*If Medicare, provide reason for entitlement (age, disabled, ESRD, transplant): ____
Are parents of dependent children divorced, separated, or not living together? ☐ No ☐ Yes – If yes, provide the name and date of birth of the parent with primary custody:
Name____ DOB________________________________
If there is a court order indicating coverage of health expenses, attach a copy for determination of benefit order.

AUTHORIZATION AND CERTIFICATION FORM

I hereby apply for insurance and/or self-funded benefits and understand that if I am not actively at work for the required number of hours according to the plan document at the time my application is approved, the coverage is not effective until the date this requirement is met. I agree the copy of my signature or copy of this form may be accepted as my signature.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my family's health, to give to the insurer, including reinsurers, such information. A photographic copy of this authorization shall be as valid as the original.

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 terms of my employer's health care plan document. I understand that benefits, once refused, may not be elected at a later date unless certain eligibility requirements are met.

______________________________________ Employee Signature

______________________________ Date (mm/dd/yyyy)