

# 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**

<b>MEDICAL</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) Coverage	PLAN OPTION _____
<b>DENTAL</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) Coverage	PLAN OPTION _____
<b>VISION</b> <input type="checkbox"/> Myself <input type="checkbox"/> 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**

<b>MEDICAL</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) Coverage	<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Dependent Life
<b>DENTAL</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) Coverage	<input type="checkbox"/> Long Term Disability <input type="checkbox"/> Supplemental Life \$ _____
<b>VISION</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) Coverage	<input type="checkbox"/> 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](mailto:eligibilityreferrals@medcost.com)