Carolina Care Plan

www.carolinacareplan.com
P.O. Box 100175
Columbia, SC 29202-3175

ENROLLMENT/CHANGE FORM

An incomplete or illegible form will cause a delay in processing.
Use Ink ONLY

Jefferson Pilot Financial

COMPANY/GROUP NAME	CAROLINA CARE PLAN GROUP ID #

☐ **IN AREA**
☐ **OUT OF AREA**

ENROLLMENT TYPE *(Please submit a Certificate of Creditable Coverage if available)*

☐ New Group
☐ Open Enrollment
☐ New Hire
☐ Rehire
☐ Late Enrollee
☐ COBRA: (qualifying event/start date) _____
☐ State Continuation: (qualifying event/start date) _____
☐ Military Continuation: (last day worked/start date) _____
☐ Newly Eligible: (reason/start date) _____
☐ Return from Leave/Layoff: (type/date) _____

CHANGE TYPE *(Check the box/boxes that apply)*

☐ Name
☐ Address/Phone Number
☐ Marriage (common law applies)
☐ Divorce
☐ Add/Delete Dependent(s)
☐ Add/Delete Product(s)
☐ Change Beneficiary
☐ Change Department
☐ Military Leave: (last day worked) _____
☐ Medical Leave: (last day worked)_____
☐ Layoff: (last day worked) _____
☐ Termination: (last day employed) _____

EMPLOYEE INFORMATION *(Please print)*

_____ ☐ Male ☐ Female
First Name MI Last Name

_____
Street Address Apt Number City State Zip Code

(_____)_____ (_____)_____ _____ _____
Home Phone Work Phone Occupation/Job Title # Hours Worked Per Week

_____-_____-_____ _____/_____/_____
Social Security Number Birth Date ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Have you previously had coverage with CCP? ☐ Yes ☐ No If yes, Group Name: _____

FAMILY INFORMATION *(Please provide the following information for family members you wish to cover on your policy)*

Action	Coverage Type	First Name	MI	Last Name	Relation to Employee	Birth Date	Sex	Status*	Prior CCP Coverage?
☐ Add ☐ Delete	☐ Medical ☐ Dental					/ /	M F	S H	Y N
☐ Add ☐ Delete	☐ Medical ☐ Dental					/ /	M F	S H	Y N
☐ Add ☐ Delete	☐ Medical ☐ Dental					/ /	M F	S H	Y N
☐ Add ☐ Delete	☐ Medical ☐ Dental					/ /	M F	S H	Y N
☐ Add ☐ Delete	☐ Medical ☐ Dental					/ /	M F	S H	Y N

* **S** = Student **H** = Handicapped

PRODUCT ELECTION *(Check all that apply)*

ALL NON-MEDICAL PRODUCTS REQUESTED IN THIS SECTION ARE PROVIDED BY JEFFERSON PILOT FINANCIAL INSURANCE COMPANY.

Medical Coverage	Dental Coverage	Other Coverage
☐ Employee Only	☐ Employee Only	☐ Employee Life/AD&D
☐ Employee + Spouse	☐ Employee + Spouse	Salary: _____ (Yearly)
☐ Employee + Child(ren)	☐ Employee + Child(ren)	Life Amount: _____
☐ Family	☐ Family	☐ Dependent Life Insurance
☐ I decline coverage for myself	☐ I decline coverage for myself	☐ Short Term Disability
☐ I decline coverage for my dependents	☐ I decline coverage for my dependents	☐ Long Term Disability

If you are declining coverage, please indicate reason: ☐ Covered under another plan ☐ Other: _____

_____ _____
Beneficiary's Full Name – **PLEASE PRINT** Relationship

				-	-
First Name		MI	Last Name	Social Security Number	

OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins, will you or any family members listed on this form be covered by any other medical /dental insurance or Medicare?

☐ No ☐ Yes (If yes, please complete the section below)

☐ Medical ☐ Dental ☐ Medicare* ☐ Medicaid* Dates of Coverage: _____ to _____

_____

Insurance Company Name Policy Number

_____

Name of Policyholder Policyholder's Birth Date

_____(_____)_____

Policyholder's Employer: Name Address Phone Number

_____

Family Members Covered

_____

*Family Members Covered by Medicare/Medicaid Medicare/Medicaid Claim Number

***Coverage Type:** ☐ Part A (effective date) _____/_____/_____ ***Medicare Eligibility Reason:** ☐ Age 65 ☐ Disability

☐ Part B (effective date) _____/_____/_____ ☐ Kidney Failure (ESRD)

EMPLOYEE SIGNATURE

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give CCP any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of a form or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided by Us on this form is true and accurate. I understand and agree that any omissions or incorrect statements knowingly made by Us on this form may invalidate my and/or my dependent's coverage, subject to time limits on certain defenses. **I realize any false statements, omissions and/or material misrepresentations regarding any information requested on this form, could cause an otherwise valid claim to be denied and/or cause the health coverage, if issued, to be cancelled as never effective.**

_____ _____

Employee Signature **(REQUIRED)** Date **(REQUIRED)**

EMPLOYER USE ONLY

CAROLINA CARE PLAN GROUP ID #	COMPANY/GROUP NAME	DEPARTMENT NAME / NUMBER	EMPLOYEE ID NUMBER
ORIGINAL HIRE DATE	**EFFECTIVE DATE OF COVERAGE**	**EFFECTIVE DATE OF CHANGE**	**EFFECTIVE DATE OF REHIRE**

EMPLOYMENT STATUS: ☐ Active ☐ Retired ☐ Other: _____

EMPLOYMENT CLASS: ☐ Hourly ☐ Salaried ☐ Non-Management ☐ Management ☐ Other: _____

GROUP APPROVAL: On behalf of the aforementioned group and myself, I agree that the information provided on this form by the employee and my self is true and accurate to the best of my knowledge. I understand that by signing this form I represent myself as the Group Benefits Administrator of the aforementioned group and accept responsibility for the approval of this form as it is submitted to CCP for processing. **I understand and agree that any omissions or incorrect statements knowingly made on this form may invalidate coverage, subject to time limits on certain defenses.**

_____ _____

Group Benefits Administrator Signature **(REQUIRED)** Date **(REQUIRED)**

_____

Group Benefits Administrator Name – **PLEASE PRINT**