



ENROLLMENT/CHANGE FORM

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

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

COMPANY/GROUP NAME	CAROLINA CARE PLAN GROUP ID #

- In Area
 Out of Area

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

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

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

<input type="checkbox"/> Name	<input type="checkbox"/> Add/Delete Dependent(s)	<input type="checkbox"/> Military Leave: (last day worked) _____
<input type="checkbox"/> Address/Phone Number	<input type="checkbox"/> Add/Delete Product(s)	<input type="checkbox"/> Medical Leave: (last day worked) _____
<input type="checkbox"/> Marriage (common law applies)	<input type="checkbox"/> Change Beneficiary	<input type="checkbox"/> Layoff: (last day worked) _____
<input type="checkbox"/> Divorce	<input type="checkbox"/> Change Department	<input type="checkbox"/> Termination: (last day employed) _____

EMPLOYEE INFORMATION *(Please print)*

First Name	MI	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address	Apt Number	City	State	Zip Code
Home Phone ()	Work Phone ()	Occupation/Job Title	# Hours Worked Per Week	
Social Security Number - -	Birth Date / /	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> 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?
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental					/ /	M F	S H	Y N
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental					/ /	M F	S H	Y N
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental					/ /	M F	S H	Y N
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental					/ /	M F	S H	Y N
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental					/ /	M F	S H	Y N

*S = Student H = Handicapped

PRODUCT ELECTION *(Check all that apply)*

Medical Coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents	Dental Coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents	Other Coverage <input type="checkbox"/> Employee Life/AD&D Salary: _____ (Yearly) Life Amount: _____ <input type="checkbox"/> Dependent Life Insurance <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability
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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 NO.
			— —

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) ____/____/____ Part B (effective date) ____/____/____
 *Medicare Eligibility Reason: Age 65 Disability 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/CLIC 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 STATUS: 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/CLIC 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