



Enrollment Form

Submit to:
Primary PhysicianCare Inc.
P.O. Box 11088
Charlotte, NC 28220
Eligibility Fax: 704-945-9595

Effective Date: 1/1/2011 New Change/Explain:

Company Name (Employer) Averett University – Group #233			
Employee's Name (Last, First, M.I.)		Date Employed Mo Day Yr	
Address		Res. # Bus. #	
City, State, Zip		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	
Please check each coverage option that is offered by your employer.			
Coverage Election	Medical & Vision Coverage		Buy Up Vision
Employee Only	<input type="checkbox"/>		<input type="checkbox"/>
Employee & Child	<input type="checkbox"/>		<input type="checkbox"/>
Employee & Family	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> I DECLINE COVERAGE			
Are you declining enrollment for yourself or your dependent because you or your dependents have coverage under another health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			

ELIGIBILITY – THIS SECTION MUST BE COMPLETED

Employee (Last, First, M.I.)		
Social Security Number	Date of Birth Mo Day Yr	Sex
Spouse (Last, First, M.I.)		
Date of Marriage		
Social Security Number	Date of Birth Mo Day Yr	Sex
#1 Dependent (Last, First, M.I.)		
Relationship to Employee		
Social Security Number	Date of Birth Mo Day Yr	Sex
#2 Dependent (Last, First, M.I.)		
Relationship to Employee		
Social Security Number	Date of Birth Mo Day Yr	Sex
#3 Dependent (Last, First, M.I.)		
Relationship to Employee		
Social Security Number	Date of Birth Mo Day Yr	Sex

Are you or any of your dependents covered by any other health insurance, supplemental policy, Medicaid, or Medicare? Yes No

If yes, name of insurance company and name of employer: _____
Name of those covered by other insurance: _____ Policy #: _____



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ENROLLMENT FORM

Employee's Name (Last, First, M.I.):

I hereby request coverage under my Employer's Health Plan and authorize my employer to deduct from my earnings any required contributions. I have a regularly scheduled work week with the employer named above at least equal to the minimum required for eligibility under the Plan. I hereby authorize all doctors and institutions that have treated or examined me or any of my dependents to release medical records and information to Primary PhysicianCare, if requested.

By signing this form, I acknowledge that I have received and read the Health Plan Required Notices.

Employee's Signature

Date

Release of Medical Information

By signing this form, I authorize my physician, medical professional, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or my dependents or their health, to give such information to Primary PhysicianCare, Inc., if requested.

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents, (including your spouse) because of other health benefit plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you do not enroll for yourself or your dependents within 30 days after your coverage ends, you may enroll as a Late Enrollee and will be subject to an eighteen (18) month waiting period before coverage can begin. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This group health plan imposes a twelve (12) month pre-existing condition exclusion on your coverage. The pre-existing condition exclusion delays coverage for a medical or mental condition for which you sought medical advice, diagnosis or care, had treatment recommended or received treatment during the six months immediately prior to our enrollment date. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the pre-existing condition exclusion may be reduced by the amount of time you had health coverage prior to your current enrollment, if the lapse of coverage was less than 64 days. The period of coverage is shown on the Certificate of Coverage that is available from your previous plan or company.

If you had prior coverage, obtain a Certificate of Coverage from your prior carrier and submit to:

**Primary PhysicianCare, Inc.
 Eligibility Department
 PO Box 11088
 Charlotte, NC 28220-1088**
