

Carolina Care Plan Application Check List

- All Medical questions must be answered, if any are answered yes, please give complete details, including Physicians name and address.
- Make sure that all applications are signed and dated. (especially on the back side of application)
- If paying via monthly Bank Draft, please also complete Bank Authorization, and attach a voided check.

You can fax your completed Application back to (803)781-7750

Or Mail to the following address:

Health Benefits ABC
Attn: David Greenhalgh
PO Box 186
Ballentine, SC 29002

FAX: (803) 781-7750

**Please feel Free to call us at any time with additional questions
(800) 861-3834**



INDIVIDUAL APPLICATION

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

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

APPLICANT INFORMATION *(Please print)*

Requested Effective Date: ____/____/____ (Policy will become effective first of the month after approval)

As of the requested effective date, will you be a resident of South Carolina? Yes No
(Only South Carolina residents are eligible for coverage)

First Name Middle Last Name Male Female

____-____-____ / ____/____/____ Single Married Widowed Divorced
Social Security Number Birth Date

Street Address Apt Number City State Zip Code

(____) (____) _____
Home Phone Work Phone Place of Employment / Job Title

Billing Address Apt Number City State Zip Code

Have you previously had coverage with CCP? Yes No If yes, provide the SSN that you were covered under: _____

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

Dependent children must be unmarried and under age 19, or under age 23 if a full-time student.

SSN	First Name	Middle	Last Name	Relation to Employee	Birth Date	Sex	Status*	Prior CCP Coverage?
					/ /	M F	S H	Y N
					/ /	M F	S H	Y N
					/ /	M F	S H	Y N
					/ /	M F	S H	Y N
					/ /	M F	S H	Y N

* S = Student H = Handicapped

PRODUCT ELECTION *(Check all desired benefits)*

Choose Your Plan:	Benefit	<input type="checkbox"/> PLAN 1	<input type="checkbox"/> PLAN 2	<input type="checkbox"/> PLAN 3	<input type="checkbox"/> PLAN 4	Optional Benefits:
	Coinsurance	70%/50%	70%/50%	70%/50%	70%/50%	
	Deductible	\$1000/\$2000	\$3000/\$6000	\$750/\$1500	\$1500/\$3000	<input type="checkbox"/> Maternity Coverage
	Out-of-Pocket Max	\$5000/\$8000	\$5000/\$8000	\$2000/\$8000	\$3000/\$8000	
	Office Visit	\$25	\$40	\$25	\$25	<input type="checkbox"/> Prescription Drug Coverage

BILLING INFORMATION *(Select billing type)*

- Monthly Bank Draft: Voided check (not deposit slip) and **Authorization Form Required.**
- List Bill (through your employer)
List Bill Account Number: _____
- Monthly Credit Card Draft: Credit Card Account Information and **Authorization Form Required.**

APPLICANT SIGNATURE

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and/or 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.

It is further understood and agreed that CCP may deny claims and may void coverage (subject to the policy's Time Limit on Certain Defenses provision) if CCP determines that any information was misrepresented on the application or any claim. If any coverage is voided, CCP will refund premiums paid minus any claims paid by CCP.

Applicant Signature (REQUIRED)

Date (REQUIRED)

Spouse's Signature (Only required if applying for coverage)

Date

.....
*** NOTE: Broker's name and signature not required if applying by mail.**

David Greenhalgh

Broker's Name (PLEASE PRINT)

DHR

Broker Code

Broker's Signature

Date



INDIVIDUAL HEALTH INFORMATION

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

NOTICE:

A separate Health Information form must be completed for each family member that you wish to cover on this policy.

APPLICANT NAME	SOCIAL SECURITY NUMBER

FAMILY MEMBER NAME	HEIGHT /WEIGHT	DATE OF BIRTH
		/ /

All of the following questions must be answered with respect to the family member listed on this form. Has this family member listed EVER had medical advice, treatment or do you know or have reasons to know of health problems in regard to questions 1-20? Check YES or NO for each question.

<p>Yes No</p> <p>1. <input type="checkbox"/> <input type="checkbox"/> Impairment of Sight, Speech or Hearing</p> <p>2. <input type="checkbox"/> <input type="checkbox"/> Tumor, Cyst or Cancer</p> <p>3. <input type="checkbox"/> <input type="checkbox"/> Fainting Attacks, Convulsions or Epilepsy</p> <p>4. <input type="checkbox"/> <input type="checkbox"/> Spine Condition or Bodily Deformity</p> <p>5. <input type="checkbox"/> <input type="checkbox"/> Nervous or Mental Disorder</p> <p>6. <input type="checkbox"/> <input type="checkbox"/> Ulcers or Stomach Disorders</p> <p>7. <input type="checkbox"/> <input type="checkbox"/> Gall bladder, Liver Disorder or Hepatitis</p> <p>8. <input type="checkbox"/> <input type="checkbox"/> Kidney, Bladder or Prostate Disorder</p> <p>9. <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids, Intestinal or Rectal Disorder</p> <p>10. <input type="checkbox"/> <input type="checkbox"/> Hemia</p> <p>11. <input type="checkbox"/> <input type="checkbox"/> Substance Abuse, Drug or Alcohol Abuse</p>	<p>Yes No</p> <p>12. <input type="checkbox"/> <input type="checkbox"/> Eyes, Ears, Nose Throat, Head or Brain Disorder</p> <p>13. <input type="checkbox"/> <input type="checkbox"/> Asthma, Sinus, Nasal, Allergies or Lung Disorder</p> <p>14. <input type="checkbox"/> <input type="checkbox"/> Disease of Bones or Joints, Arthritis or Rheumatism</p> <p>15. <input type="checkbox"/> <input type="checkbox"/> Blood Disorder, Anemia, Leukemia or Hemophilia</p> <p>16. <input type="checkbox"/> <input type="checkbox"/> Menstrual Disturbances or other Female Disorders</p> <p>17. <input type="checkbox"/> <input type="checkbox"/> High or Low Blood Pressure, Heart Trouble or Vascular Disease</p> <p>18. <input type="checkbox"/> <input type="checkbox"/> Abnormal Cholesterol or Lipid Disorder</p> <p>19. <input type="checkbox"/> <input type="checkbox"/> Disease of Endocrine System, Thyroid, Goiter or Diabetes</p> <p>20. <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Diseases such as syphilis, gonorrhea, herpes or genital warts</p> <p>21. <input type="checkbox"/> <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Kaposi Sarcoma, Pneumocystis, Carinii Pneumonia, or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III)</p>
<p>Yes No</p> <p>22. <input type="checkbox"/> <input type="checkbox"/> Been advised to undergo surgery within the next six months?</p> <p>23. <input type="checkbox"/> <input type="checkbox"/> Ever been advised to undergo a surgical operation that was not performed?</p> <p>24. <input type="checkbox"/> <input type="checkbox"/> Ever used any narcotics or controlled substances, except as legally prescribed by a physician?</p> <p>25. <input type="checkbox"/> <input type="checkbox"/> Ever had any other abnormality, birth defect, developmental defect, anomaly, behavioral or educational problem, disorder or disease?</p> <p>26. <input type="checkbox"/> <input type="checkbox"/> Used any form of tobacco in the past 12 months?</p> <p>27. <input type="checkbox"/> <input type="checkbox"/> Currently taking any medicine(s), drugs or pills, or require shots? (Provide medication name, dosage and frequency.)</p> <p>28. <input type="checkbox"/> <input type="checkbox"/> Currently disabled or pregnant?</p> <p>29. <input type="checkbox"/> <input type="checkbox"/> Ever been declined, rated, restricted or modified for issuance of life, accident or health insurance?</p> <p>30. <input type="checkbox"/> <input type="checkbox"/> Ever had medical advice, treatment, or any known indications of health problems not mentioned in the questions above?</p>	

**Please provide full details for any boxes checked or questions answered "YES" above.
PLEASE PRINT and use additional paper if needed.**

#	Name of Illness/Disorder	Types of Treatment Received (including any medication)	Treatment Dates From To	Name & Address of Attending Physician

Name and address of your current family physician: _____

OTHER HEALTH INSURANCE INFORMATION

On the day this coverage begins, will any other medical insurance or Medicare cover you? No Yes (If yes, complete the section below)

Medical 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)

APPLICANT SIGNATURE

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and/or 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.

It is further understood and agreed that CCP may deny claims and may void coverage (subject to the policy's Time Limit on Certain Defenses provision) if CCP determines that any information was misrepresented on the application or any claim. If any coverage is voided, CCP will refund premiums paid minus any claims paid by CCP.

Family Member's Signature (REQUIRED)

Date (REQUIRED)

Parent or Guardian Signature (if family member is under 18 years old) (REQUIRED)

Date (REQUIRED)



Automatic Payment for Individual Health Premiums

There is an easier way to pay your monthly Carolina Care Plan[®], Inc. premiums!

With Automatic Payment, your bank or credit card account will be drafted automatically on the 1st business day of the month after approval of your application for health coverage.

- Saves you money by eliminating the need to write monthly checks.
- Improves timely posting of your Carolina Care Plan payment.

It's easy to sign up!

1. Complete the information below.
2. Attach a voided check or provide the required credit card information.
3. Return this information along with your Application.

Yes, I authorize Carolina Care Plan, Inc. and the bank/credit card company named below to initiate monthly withdrawals from my bank or credit card account. The authority will remain in effect until I notify Carolina Care Plan and my bank/credit card company at least 30 days before my account is charged. I understand the terms and conditions on this form. I have attached a voided check or provided the required credit card information.

CREDIT CARD ACCOUNT INFORMATION

Card Type: VISA Mastercard

Card Number: --- Expiration Date (MO/YR): /

Cardholder's Name (Please print): _____

Is your credit card billing address the same as the billing address at the beginning of this application? Yes No
If no, please provide your credit card billing address:

_____	_____	_____	_____
Address	City	State	Zip Code

I authorize Carolina Care Plan, Inc. to charge the account listed above monthly.

Cardholder's Signature (REQUIRED) _____

Date (REQUIRED) _____

BANK ACCOUNT INFORMATION

_____	(____) _____ - _____
Name of Bank/Institution	Phone Number

_____	_____	_____	_____
Address	City	State	Zip Code

Account Name (Please print): _____

Authorized Signature (REQUIRED) _____

Date (REQUIRED) _____