

**PRIOR COVERAGE INFORMATION
OTHER COVERAGE INFORMATION**

EMPLOYEE NAME	MEMBER ID NUMBER	EMPLOYING UNIT
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SECTION I - Prior Coverage

A. I am applying for coverage in the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and since I did not enroll when first eligible, I wish to receive credit against the waiting period for pre-existing conditions. I had previous health coverage which was continuous to a date not more than sixty-three (63) days before the effective date of coverage in the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan. (Please give the information requested below in reference to the Plan by which you were most recently covered.)

NAME OF COVERED INDIVIDUAL	NAME OF PREVIOUS PLAN AND EMPLOYER	DATE COVERAGE BEGAN	DATE COVERAGE ENDED
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B. I am applying for dependent coverage in the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and since I did not enroll when first eligible, I wish to receive credit against the waiting period for pre-existing conditions. The dependent(s) listed below had previous health coverage which was continuous to a date not more than sixty-three (63) days before the effective date of coverage in the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan. (Please give the information requested below in reference to the Plan by which you were most recently covered.)

NAME OF COVERED INDIVIDUAL	NAME OF PREVIOUS PLAN AND EMPLOYER	DATE COVERAGE BEGAN	DATE COVERAGE ENDED

I authorize my prior health plan to furnish the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan information concerning prior coverage including the type of coverage provided, the effective date and the termination date of the health plan provided to me and/or my dependents.

Employee Signature _____ Date _____

SECTION II - Other Coverage

A. Do you or any member of your family have group coverage other than the North Carolina Teachers' and State Employees' Major Medical Plan? (This does not include Medicare.) Yes No

NAME OF POLICYHOLDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
EMPLOYER NAME	EMPLOYER ADDRESS (STREET, CITY, STATE AND ZIP CODE)	
INSURANCE COMPANY	INSURANCE COMPANY ADDRESS (STREET, CITY, STATE AND ZIP CODE)	
GROUP NUMBER	POLICY NUMBER	EFFECTIVE DATE OF POLICY
TYPE OF POLICY		<input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT/CHILD <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> INDIVIDUAL

B. If children are being enrolled, please fill out the following:

THE NAME OF THE INDIVIDUAL WITH LEGAL RESPONSIBILITY (BY COURT DECREE) FOR THE CHILDREN'S HEALTH CARE
THE NAME OF THE INDIVIDUAL(S) WITH LEGAL CUSTODY OF THE CHILD(REN)

I hereby authorize the above insurance company to release to the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan any information necessary to process claims payment under the Plan.

Signature of Policyholder of Other Coverage _____ Date _____