Carolinas AGC
NC Health Plan

CAGC NC Enrollment / Change Form

Office Use Only	
Company Info.	Business Name: _____ Contact Name:_____ Phone:_____ Email:_____
Enrollment	☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ Qualifying Event
Change	☐ Personal Information ☐ Beneficiary ☐ Add Dependent ☐ Other: _____
Termination	Termination Date: _____ Coverage End Date: _____ Reason: _____
Qualifying Event	☐ Marriage/Divorce ☐ Birth/Adoption ☐ Court Order ☐ Loss of Coverage ☐ FT to PT (last day of FT Coverage _____)

Employee Information			
Social Security Number	Last Name	First Name	MI
Home Street Address Apt		City, State, Zip	
Date of birth	Date of hire	Gender (required) ☐ Male ☐ Female	

Dependent Information						
Last Name	First Name	SSN	Date of Birth	Gender (M / F)	Relationship	Coverage
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision

Elections						
Medical				Dental		Vision
Platinum Plan	Gold Plan	Silver Plan	HDHP H.S.A Plan	High Plan	Low Plan	
☐ Employee Only $817.45	☐ Employee Only $695.49	☐ Employee Only $610.87	☐ Employee Only $451.65	☐ Employee Only $44.31	☐ Employee Only $38.89	☐ Employee Only $12.75
☐ Employee + Spouse $1,801.35	☐ Employee + Spouse $1,533.07	☐ Employee + Spouse $1,346.91	☐ Employee + Spouse $996.63	☐ Employee + Spouse $88.62	☐ Employee + Spouse $77.81	☐ Employee + Spouse $20.63
☐ Employee + Children $1,559.12	☐ Employee + Children $1,327.42	☐ Employee + Children $1,166.63	☐ Employee + Children $864.14	☐ Employee + Children $106.07	☐ Employee + Children $92.86	☐ Employee + Children $21.50
☐ Family $2,543.04	☐ Family $2,164.99	☐ Family $1,902.68	☐ Family $1,409.13	☐ Family $162.13	☐ Family $141.90	☐ Family $29.73
☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____

I have read this form and the other materials given to me about my benefits and certify the information I have supplied is correct. I understand that misstatements, misrepresentations, or omissions may result in my coverage being canceled. In addition, I understand that intentionally providing false information constitutes fraud and is subject to disciplinary action up to and including termination.

I also understand that the benefit coverages I elect on this form will be in effect for the entire plan year unless I experience a qualified status change event and request a change to my benefits within 30 days of such event. By signing and submitting this enrollment form, I authorize CAGC and/or affiliates to deduct from my earnings or wages voluntary contributions to company-sponsored employee benefit programs. I understand that my contributions for the medical, dental and vision coverage (if elected) will be deducted pre-tax. I also understand that I am liable for these deductions pursuant to such authorization and acknowledge that it is my responsibility to verify that these payroll deductions are correct. I will notify human resources immediately in writing upon discovering any discrepancy.

Employee Signature: _____ Date: _____