Vance-Granville Community College

STATE HEALTH PLAN ENROLLMENT APPLICATION FORM 2019

☐ New Hire ☐ Annual Enrollment ☐ Change ☐ I wish to decline **all** benefits

EMPLOYEE INFORMATION

Hire Date:_____/_____/_____ **Effective Date**_____ **Social Security #:**_____-_____-_____

Employee Name: Last_____ First_____ MI_____ **Sex** (circle one): ☐ **M** ☐ **F**

Home Address: Street _____ City_____ State_____ Zip_____

Home Phone #: (_____)_____ **Email Address:**_____ **DOB:**_____/_____/_____

MEDICAL PLANS - MONTHLY RATES

ACTIVE/NON-MEDICARE PRIMARY FOR EMPLOYEE/RETIREE AND DEPENDENT(S) Rates below are after wellness activities are completed, if applicable. See monthly premium rate chart		**NON-MEDICARE PRIMARY FOR EMPLOYEE/RETIREE AND DEPENDENT(S)**
ENHANCED 80/20 A Preferred Provider Organization (PPO) plan. This plan includes the ability to lower your monthly premium by completing wellness activities.	**TRADITIONAL 70/30** A Preferred Provider Organization (PPO) plan.	**HIGH DEDUCTABLE** The HDHP benefit option is available only to employees eligible for coverage under G.S. §135 48.40(e).
☐ **Employee Only: $50.00**	☐ **Employee Only: $25.00**	☐ **Employee Only: $96.00**
☐ **Employee + Child(ren): $305.00**	☐ **Employee + Child(ren): $218.00**	☐ **Employee + Child(ren): $284.00**
☐ **Employee + Spouse: $700.00**	☐ **Employee + Spouse: $590.00**	☐ **Employee + Spouse: $513.00**
☐ **Family: $720.00**	☐ **Family: $598.00**	☐ **Family: $617.00**

3 STEPS TO ENROLLMENT

1. Select your medical health benefits plan by completing and signing this form.
2. Your employer will set up a profile in the benefits enrollment system and generate a userid for you. You must go to the "State Health Plan website" using the link below to complete the enrollment process which includes verifying the health benefits plan that you selected above, selecting your physician, taking the tobacco attestation and responding to any other questions. https://nc.secure-enroll.com/go/bcbsnc/
3. Complete your health assessment by going to "My Personal Health Portal" using the link below within 24 hours of initial enrollment to receive credit for the full discounted price. https://www.myactivehealth.com/portal/

PAYROLL DEDUCTION AUTHORIZATION

I hereby elect coverage under the plan listed above for myself and eligible family dependents listed on the form above and I agree that the information provided is correct. I further agree that we shall abide by the provisions of the Agreement for the plan in which we are enrolling.
I hereby authorize my employer, until I revoke by written notice, to deduct from my earnings the employee contribution required for the above coverage. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization or institution that has any records or knowledge of the health of any covered member of my family to exchange such information with the plan I have selected.

Employee Signature: _____ **Date Signed:**_____