



SCMA Members' Insurance Trust

A subsidiary of the South Carolina Medical Association

P.O. Box 11188 | Columbia, SC 29211 Telephone 803-798-6207 | 1-800-327-1021 ext. 237, 239, 425 | Fax 803-731-4021

COMPLETE THIS APPLICATION IN FULL FOR YOURSELF AND ALL FAMILY MEMBERS TO BE COVERED.

If not enrolling in this coverage, complete items #2, 4, 5, 6 and complete waiver on reverse side.

Please print clearly.

1. Check the action needed:

- A. New Add Date employed at this location: _____ **If Physician, give S.C. Medical License # _____**
- B. Change Type of Membership (See #8) **E-mail Address: _____**
- C. Transfer Within Your Group (Standard, Choice Plus, HD, RAP, Medicare Supplement, HSA)
- D. Terminate Coverage Effective: _____
Left Employment: Yes No Deceased: Yes No Cobra or Conversion? (Circle One)
- E. Name Change From: _____ To: _____
- F. Other: _____

2. Member Name: _____ 3. Male 4. Social Security #: _____
 Female _____
 (Last) (First) (MI)

5. Home Mailing Address: _____ 6. Birth Date: Month/Date/Year: _____
 (Street) (City) (County) (State) (Zip)

7. Effective Date Requested: _____ 8. (a) Type of Health Membership:
 Member Only Member/Spouse Member/Children Family
 8. (b) Type of Dental Membership:
 Member Only Member/Spouse Member/Children Family

9. Plan Selection: **Major Medical Plans**

	<input type="checkbox"/> Standard	<input type="checkbox"/> Choice Plus	<input type="checkbox"/> High Deductible
Deductible	\$300	\$500	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
Co-Insurance	85%/75%	<input type="checkbox"/> 80%/60% <input type="checkbox"/> 70%/50%	<input type="checkbox"/> 80%/60% <input type="checkbox"/> 70%/50%
Plan Design	<input type="checkbox"/> Major Medical Only <input type="checkbox"/> Drug Card & Office Visit Co-pay	<input type="checkbox"/> Major Medical Only <input type="checkbox"/> Drug Card & Office Visit Co-pay	<input type="checkbox"/> Major Medical Only <input type="checkbox"/> Drug Card & Office Visit Co-pay

HSA Plans

- Plan I Plan II Plan III Plan IV RAP

Medicare Supplement Plans

- Plan B Plan E Plan J

10. Practice Name & Address: _____ If existing Group, give MIT Location #: _____

11. Name & Address of your Previous Health Insurance Carrier: _____

12. List all eligible dependents to be covered					
	Last Name	First Name	Date of Birth	Male/Female	Social Security Number
Spouse					
Child					
Child					
Child					
Child					
Child					

13. A) Are you or any member of your family covered by any other Group Health Insurance? Yes No

If yes, please furnish name and address of that insurance company: _____

B) Does any above mentioned member of your family have Medicare? Yes No If yes, Name: _____

PLEASE READ CAREFULLY BEFORE SIGNING

The undersigned authorizes any physician or other provider of health services to release to the Members' Insurance Trust and its agents, upon request, any information including medical records concerning the health condition or treatment of any person included under such coverage whenever such information is considered necessary by the plan for proper processing of this application or for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed of the Members' Insurance Trust by state or federal statutes.

I fully understand and agree (1) That Members' Insurance Trust has the right to accept or reject the insurance applied for in this application and (2) If the Members' Insurance Trust approves coverage, the Members' Insurance Trust will determine the effective date of such coverage and (3) That no insurance coverage shall be in force until the Members' Insurance Trust receives the application, approves coverage, and receives payment of premium and (4) If coverage is approved, the undersigned will receive an insurance booklet and identification cards.

It is further understood and agreed that Members' Insurance Trust may deny claims and may void any coverage if the Members' Insurance Trust determines that any information was misrepresented in the application or any claim. If coverage is voided, the Members' Insurance Trust will refund premiums paid minus any claims paid.

It is further understood that prior plan approval must be obtained for all designated services. The undersigned also understands that there will be a 12 month exclusion from the coverage for any preexisting conditions, unless the Members' Insurance Trust is furnished with proof of prior credible coverage. It is also understood that a waiver of the preexisting exclusion can be given only to the extent satisfied by the previous coverage.

The undersigned hereby represent(s) that the information on this application and any other information furnished by the undersigned is complete and true and correctly recorded.

I have read and understood each and every part of this enrollment application.

Date: _____ Signature of Member or Employee: _____



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HEALTH QUESTIONNAIRE

(If additional space is needed, use back of page)

Member Name: _____ SSN: _____

PLEASE BE SURE TO COMPLETE ALL INFORMATION FOR YOURSELF AND DEPENDENTS.

To the best of your knowledge and belief, has any person on whom coverage is applied for in this application:

(Answer questions by (✓) the "Yes" or "No" box in the appropriate places.)

Item #	Question	Emp.		Spouse		Child	
		Yes	No	Yes	No	Yes	No
1.	Ever had any deformity, amputation or physical disability?						
2.	Ever had alcohol or drug dependency, overdose, reaction or abuse (includes counseling by any organization or counselor)?						
3.	Ever been told he/she has Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex or ever tested positive for HIV virus?						
4.	Ever had or been told that he/she had dizziness, fainting spells, epilepsy, nervous breakdown, or mental disorder?						
5.	Ever had high blood pressure, chest pain, heart attack, heart murmur, varicose veins, phlebitis or poor circulation?						
6.	Ever had lung or respiratory system problems, including shortness of breath, asthma, hayfever, allergies, chronic cough, tuberculosis, emphysema or pneumonia?						
7.	Ever had muscular or skeletal disease including back, joints, bones, muscles, spines, gout, arthritis, or rheumatism?						
8.	Ever had disease or disorder of the eye, ear, nose, throat, or mouth?						

Item #	Question	Emp.		Spouse		Child	
		Yes	No	Yes	No	Yes	No
9.	Ever had disease of the stomach, gall bladder, liver, or digestive system, intestines, or bowel, kidney, bladder, or prostate?						
10.	Ever had any type of cancer, tumor, goiter, thyroid, anemia or hemophilia?						
11.	Ever had or been told that she had any tumor or disease of the breast or other female organs or complications of pregnancy?						
12.	Currently pregnant?						
13.	Ever had diabetes, elevated blood sugar, blood sugar or albumin in the urine?						
14.	Do you smoke? # of packs per day _____						
15.	Currently taking prescription medications? If yes, please list prescription and dosages below.						
16.	Has any medical professional recommended that you have treatment you have not yet received? If yes, please describe below.						

DETAILS FOR QUESTIONS 1 THROUGH 16 ABOVE.

If any answers are yes, give full details below, referring to the item numbers above.

Item #	Name	Disease	Date	Details	Name and Address of Physician and Hospital

Signature: _____ Date: _____