North Carolina
State Health Plan
for Teachers and State Employees
www.shpnc.org

PRIOR COVERAGE INFORMATION
OTHER COVERAGE INFORMATION

EMPLOYEE NAME	MEMBER ID NUMBER	EMPLOYING UNIT

SECTION I - Prior Coverage

A. I am applying for coverage in one of the plans made available through the North Carolina State Health Plan for Teachers and State Employees 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 one of the plans made available through the North Carolina State Health Plan for Teachers and State Employees. (Please give the information requested for your most recent coverage.)

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

B. I am applying for dependent coverage in one of the plans made available through the North Carolina State Health Plan for Teachers and State Employees 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 on of the plans made available through the North Carolina State Health Plan for Teachers and State Employees. (Please give the information requested for your most recent coverage.)

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 State Health Plan for Teachers and State Employees 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 one of the plans made available through the North Carolina State Health Plan for Teachers and State Employees? (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 ☐ FAMILY ☐ EMPLOYEE/SPOUSE ☐ PARENT/CHILD ☐ 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 State Health Plan for Teachers and State Employees any information necessary to process claims payment under the Plan.

Signature of Policyholder
of Other Coverage _____ Date _____