



Phone (706) 841-7000 • Toll Free (877) 937-9602
Fax: (706) 841-7020 • www.nifmcp.com

ENROLLMENT FORM

Return the completed form by fax to (706) 841-7020, by email to fmcpsc@nifmcp.com or by mail to:
NECA/IBEW Family Medical Care Plan
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741

EMPLOYEE INFORMATION

Name of Employee: _____ SSN: _____

Mailing Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: M F Marital Status: Single Married Divorced Separated Widowed

Email: _____ Current Employer: _____

Coverage Election: Employee Only Employee + Spouse Employee + Children Family

SPOUSE INFORMATION

Name of Spouse: _____ SSN: _____

Date of Birth: _____ Sex: M F Marriage Date: _____ ATTACH A COPY OF MARRIAGE CERTIFICATE.

CHILD INFORMATION

List all dependent children under age 26 if you have chosen Employee + Children or Family Coverage.

Full Legal Name	Relationship to You (natural child, stepchild, etc.)	Child's SSN	Date of Birth	Sex
1.				
2.				
3.				
4.				

FOR ANY NEWLY ENROLLED CHILD LISTED ABOVE, PLEASE SUBMIT A COPY OF THEIR BIRTH CERTIFICATE(S) OR COPIES OF ALL PERTINENT COURT ORDERS (DIVORCE DECREES, CUSTODY AWARDS, PATERNITY ORDERS, ETC.).

OTHER INSURANCE

Name of any family member through which other group coverage is provided: _____

Name, address, phone number, and group/member I.D.s for that health plan: _____

LIFE INSURANCE BENEFICIARY (if applicable*)

*Contact your employer to verify whether you have this benefit.

Designate one or more beneficiaries for your Life Insurance and AD&D Insurance benefits.

Primary Beneficiary #1:

Full Legal Name: _____ SSN: _____

Address: _____ Relationship to You: _____

Phone Number: _____ Date of Birth: _____ % of Total (must be equal to 100%) _____

Primary Beneficiary #2 (optional):

Full Legal Name: _____ SSN: _____

Address: _____ Relationship to You: _____

Phone Number: _____ Date of Birth: _____ % of Total (must be equal to 100%) _____

Contingent Beneficiary #1 – Insurance benefits will only be paid to a contingent beneficiary if there is no surviving primary beneficiary:

Full Legal Name: _____ SSN: _____

Address: _____ Relationship to You: _____

Phone Number: _____ Date of Birth: _____ % of Total (must be equal to 100%) _____

Contingent Beneficiary #2 (optional):

Full Legal Name: _____ SSN: _____

Address: _____ Relationship to You: _____

Phone Number: _____ Date of Birth: _____ % of Total (must be equal to 100%) _____

The above-named beneficiary supersedes any and all beneficiaries previously designated. Designation of a beneficiary on this form will be valid only if the Benefit Office receives this form while you (the employee) are still living.

Employee Signature

Date