Membership Application

SCMA Members' Insurance Trust
P.O. Box 11188 Columbia, SC 29211
phone (803) 798-6207 fax (803) 731-4021

❑ New Enrollee	❑ Change Member/Dependent Election		❑ Change Plan	❑ Other
❑ Terminate Coverage	Effective Date	Date Left Employment ___/_____/_____	Deceased ❑ Yes ❑ No	Continuation of Coverage ❑ Cobra ❑ Other
❑ Name Change	Name Change From:		Name Change To:	

Member Information *All info required for New Enrollee Applications.*

Effective Date Requested		Hire Date	If existing group, give MIT Location Number:	
Last Name		First Name	Middle Initial	
Gender ❑ Male ❑ Female	Birth Date: MM/DD/YYYY	Social Security Number	Physician ❑ Yes ❑ No	SCMA Member #
Home Address		City/State/Zip	County	
Member Phone Number		Member Email Address		
Practice Name		Practice Address	City/State/Zip	
If existing group, give MIT Location Number:		Name of Previous Health Insurance Carrier	Address of Previous Health Insurance Carrier	

Are you or any member of your family covered by any other group health insurance or plan? ❑ Yes ❑ No
If yes, provide name and address of the insurance company:

Do you or any member of your family have Medicare? ❑ Yes ❑ No
If yes, provide family member's name and copy of Medicare card(s):

Eligible Dependents

Name (Last, First, MI)	Birth Date	Gender	Social Security Number
Spouse		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	

Member/Dependent Election

Type of Health Membership			Type of Dental Membership		
❑ Member Only	❑ Member/Child		❑ Member Only	❑ Member/Spouse	❑ Member/Children
❑ Member/Spouse or Member/Children		❑ Family	❑ Family		

Plan Selection

Major Medical Plans	❑ Major Medical Only	❑ Enhanced Benefit Package (Prescription Drug Card & Office Visit Co-pay)				
Deductible Option	❑ $500	❑ $1,000	❑ $1,500	❑ $2,000	❑ $3,000	❑ $5,000
HDHP Plans	❑ Plan I	❑ Plan II	❑ Plan III	❑ Plan IV	❑ Plan V	❑ Plan VI
Preferred Plans	❑ Premier	❑ Prime	❑ Select	❑ Essential		
	❑ Premier Plus	❑ Prime Plus	❑ Select Plus	❑ Essential Plus		

Acknowledgement *Signature required.*

PLEASE READ CAREFULLY BEFORE SIGNING

The undersigned authorizes any and all physicians and/or other providers of health services to release to the MIT and its agents, upon request, any and all information including but not limited to medical records concerning the health condition or treatment of any person included under such coverage whenever such information is considered necessary or appropriate by the MIT for proper processing of this application or for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed upon the MIT by state or federal statute of rules, or for any other appropriate purpose.

I fully understand and agree (1) That the MIT has the right to accept or reject the insurance applied for in this application and (2) If the MIT approves coverage, the MIT will determine the effective date of such coverage and (3) That no insurance coverage shall be in force until the MIT 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 the MIT may deny claims and may void and rescind any coverage if the MIT determines that any information was intentionally misrepresented in the application or any claim. If coverage is voided and rescinded, the MIT will refund premiums paid for the applicable period coverage would have applied minus any claims paid.

It is further understood that prior plan approval must be obtained for all designated services. We may also require additional forms and/or documents to be signed by you or other persons in order to complete your application process.

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.

Print Employee Name	Date
Employee Signature	