SCMA
MEMBERS' INSURANCE TRUST

P.O. Box 11188
Columbia, SC 29211

1-800-327-1021
803-731-4021 Fax

www.scmamit.com

Membership Application

☐ New Enrollee/Rehire Full-Time Date of (Re)Hire:	☐ Coverage Change Date of Occurrence: Reason:	☐ Terminate Coverage Date Left Employment:	☐ Continuation of Coverage COBRA Start Date:
Effective Date Requested:	☐ Name Change Change From:	Change To:	

Employee Information: All information required for New Enrollee Applications

Name (Last, First, MI):	Birthdate:	Marital Status: ☐Single ☐Married	Gender ☐Male ☐Female

Street Address:	City:	State:	ZIP:	County:

Social Security Number:	Phone Number:	Email Address (Required):

Employee Class ☐Hourly ☐Salary	# Hours Worked Per Week:	Salary (if non-physician):	Physician ☐Yes ☐No	SCMA Member #:

Name of Employer:	Employer MIT Group Number:

Enrollment Information for Eligible Dependents

Name (Last, First, MI):	Birthdate: (mm/dd/yyyy)	Gender: (M/F)	Social Security Number:	Other Insurance: (Yes/No)	Other Insurance Name:
Spouse:					
Child:					
Child:					
Child:					
Child:					

Medical Election (includes embedded Basic Life, AD&D, & Short-Term Disability (for *non-physician* member)*)

☐Member Only ☐Member/Child ☐Member/Spouse or Member/Children ☐Family

☐No Medical Coverage Due to:
☐Covered by Spouse (Carrier:_____) ☐Other Coverage (Carrier:_____) ☐Other (Reason:_____)

Major Medical Plans	☐Choice Plus ☐HD 1000 ☐HD 2000 Enhanced ☐HD 5000
HDHP Plans	☐Option I ☐Option II ☐Option III ☐Option IV ☐Option VI ☐Option VII ☐Option VIII
Preferred Plans	☐Premier Plus ☐Prime Plus ☐Select Plus ☐Value Plus

*Enrollment in embedded benefits is automatic for employee/member

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Dental Election (if offered by Participating Employer)			
☐ Member Only ☐ Member/Spouse ☐ Member/Child(ren) ☐ Family			
☐ No Dental Coverage Due to: ☐ Covered by Spouse (Carrier:_____) ☐ Other Coverage (Carrier:_____) ☐ Other (Reason:_____)			
Vision (if offered by Participating Employer)			
☐ Member Only ☐ Member/Spouse ☐ Member/Child(ren) ☐ Family ☐ No Vision Coverage			
If electing vision coverage, select plan ☐ V175 ☐ V250			
Voluntary Life and AD&D Coverage (if offered by Participating Employer)			
☐ Employee $_____ ☐ Spouse $_____ ☐ Child(ren)$_____ ☐ No Coverage			
If electing voluntary life coverage, complete The Hartford enrollment form at https://scmamit.com/forms-resources			
Value Added Benefits & Services (if offered by Participating Employer)			
Critical Illness	☐ $10,000 ☐ $20,000 ☐ $30,000	☐ Employee (child coverage is automatic) ☐ Spouse	
Accident Insurance	☐ Plan 1.1 ☐ Plan 2.1	☐ Member Only ☐ Member/Spouse ☐ Member/Child(ren) ☐ Family	
Hospital Indemnity	☐ Member Only ☐ Member/Spouse ☐ Member/Child(ren) ☐ Family		

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	