ENROLLMENT FOR
CANCER MEDICAL REIMBURSEMENT PLAN TO:
NORTH CAROLINA MUTUAL LIFE INSURANCE COMPANY
411 West Chapel Hill Street Durham, NC 27701

Cancer Medical Reimbursement Plan Enrollment Form

GENERAL INFORMATION **Group #** _____

Applicant's Name: _____ Gender _____

Date of Birth: _____ SSN: _____

Home Address: _____

_____ Phone: _____

Annual Premium: ☐$46.00 Self ☐$52 Family

Do you and all persons to be covered have major medical coverage as sponsored by your employer? ☐Yes ☐No

Are you or any person to be covered Medicare eligible: ☐Yes ☐No

Have you received the Guide to Health Insurance for People with Medicare? ☐Yes ☐No

SPOUSE AND DEPENDENT INFORMATION

Spouse/Dependent Name	Relationship to Applicant	Date of Birth	SSN

I understand that under the the CANCER & SPECIFIED DISEASE REIMBURSEMENT PLAN (CMRP) I am participating in group insurance benefits. All statements contained in the application shall, in the absence of fraud, be deemed representations and not warranties. These benefits are provided under a group insurance policy underwritten by North Carolina Mutual Life Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the Master Policy which includes, but is not limited to, limitations for pre-existing conditions.

This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a CANCER & SPECIFIED DISEASE REIMBURSEMENT PLAN (CMRP) that provides limited coverage. The limitations are disclosed in the policy and certificate, which are made available at the time of enrollment.

[**Arizona Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.]

[**California Residents:** Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

I hereby apply for participation in a group insurance program of the: North American Insurance Trust.

Signed at: City _____ State _____

Date _____ Signature of Applicant _____

PAYMENT OPTIONS

☐ **Enclosed is my check made payable to Thomas E. Mestmaker / CMRP**

☐ **You are hereby authorized to charge my Visa/MasterCard as designate in the amount of $_____ for the first annual premium.**

Check one: ☐MasterCard ☐Visa

Credit Card # _____ Exp. Date _____

☐ **Premium Payroll Deduction Authorization**

The amount of deduction shall be determined by the frequency and based on a plan that would comply with premium rate checked below.

Employee Only	**Employee and Family**
☐10 payments of $4.60	☐10 payments of $5.20
☐12 payments of $3.84	☐12 payments of $4.34

Employee Name _____ SSN # _____

I hereby authorize my employer _____, in City/State _____ to deduct my earnings such amounts as may now or hereafter be payable by me under the Cancer Medical Reimbursement Plan administered by Thomas E. Mestmaker & Associates. Excess loss coverage by North Carolina Mutual Life Insurance Company.

Signature of Applicant _____

Date _____

Mail completed, signed application to:

Mestmaker & Associates
PO Box 2302
Bakersfield, CA 93303
661.325.5999