For internal use only:	
Received date:	Effective date:

Please provide the following information in print.			
☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.	First name Middle initial Last name		
Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number
Permanent residence street address (*cannot be a post office box*)		City	State
ZIP code	County	Email address (optional)	
Mailing address (*if different from your permanent residence address*)			
Street address	City	State	ZIP code
Optional information			
Emergency contact name			
Relationship to you	Phone number		

Please provide your Medicare insurance information		
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. OR • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card)	
	Medicare number	
	Is entitled to	Effective date
	Social Security Number	
	You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

Please sign below. **By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Summary of Benefits and Star Rating**			
Signature		Today's date	
If you are the authorized representative, you must sign above and provide the following information.			
Name			
Address			
City		State	ZIP code
Phone number	Relationship to enrollee		

Please send your completed enrollment application to:

<name> Western North Carolina Conference
<address> PO Box 2757
<City State, ZIP> Huntersville, NC 28070

Or email to: <Email address> dbryant@wnccumc.org