

Check Desired Coverage:

	Plan I	Plan II	Plan III	Plan IV
Retiree				
Spouse				

Please be sure to date and sign this form, answering all questions. Make your check payable to: **NPRIT/NPRIT** and return it to:

NEBCO/NPRIT
144 Metro Center Blvd. Suite 1
Warwick, RI 02886

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage or 6 months treatment free. I (we) understand that if I (we) plan on replacing any existing group medical coverage with this plan, then this pre-existing condition limitation will be waived to the extent it was satisfied under the previous policy. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____
(if enrolling)

Office Use Only

Certificate Effective Date: