Employer Application and Change Form

NCMS *North Carolina Medical Society Employee Benefit Plan*

For NCMS Plan Use Only

Group Number:_____ RAF:_____

Please read and complete all sections of this application.

A. EMPLOYER INFORMATION (Please type or print)

EMPLOYER NAME (Provide complete legal name) | FEIN (Federal Employer Identification Number) | MEDICAL SPECIALTY

MAILING ADDRESS | CITY | STATE | ZIP CODE | COUNTY

PHYSICAL ADDRESS (If different than Mailing Address) | CITY | STATE | ZIP CODE | COUNTY

PHONE NUMBER | FAX NUMBER | E-MAIL | GROUP ADMINISTRATOR ☐DR. ☐MR. ☐MRS. ☐MS. | TITLE

PREVIOUS MEMBER OF NCMS PLAN? ☐NO ☐YES If YES, withdrawal date:_____

EMPLOYER TYPE ☐Corporation ☐S-Corporation ☐Professional Assoc. ☐LLC ☐Partnership ☐Other:_____

DO ANY ELIGIBLE EMPLOYEES RESIDE OUTSIDE THE STATE OF NORTH CAROLINA? ☐NO ☐YES If YES, list states:_____

B. HEALTH INSURANCE PROGRAM ENROLLMENT INFORMATION

PRODUCT(S)

PPO	☐1000-70 ☐1500-70 ☐2000-80 ☐2000-70 ☐2500-80 ☐2500-70 ☐2500-60 ☐3500-80 ☐3500-70 ☐3500-60 ☐4000-70 ☐5000-60 ☐5000-70 ☐6000-60 ☐7900-100
PPO 1-2-3	☐1500 ☐2000 ☐2500 ☐3500 ☐4000 ☐5000 ☐5000 (alternate Rx)
HDHP	☐2700-100 ☐2700-80 ☐3500-100 ☐3500-70 ☐5000-100 ☐6350-100 ☐5500-70 ☐7000-100 ☐8550-100

All employers may offer two products. Employers with more than 16 enrolled employees may select three products.
If offering an HSA administered by HealthEquity, complete and submit an Employer HSA Addendum.

PROPOSED COVERAGE EFFECTIVE DATE

PRIOR CARRIER (IF ANY AND ATTACH COPY OF MOST RECENT BILLING STATEMENT)

If applicable, are you offering an HSA in conjunction with an HDHP product? ☐NO ☐YES

If offering an HSA, who will serve as your HSA administrator? ☐HealthEquity ☐Other (please name)_____

Are you currently using Flores COBRA Services? ☐NO ☐YES

If no and your practice is subject to COBRA, would you like Flores to administer COBRA for you? ☐NO ☐YES

If currently on a BCBSNC direct plan, are you using eBenefitsNow or Employer Services to maintain your enrollment? ☐NO ☐YES

Does your practice use an automated file feed or third party vendor to transmit enrollment data to your current carrier? ☐NO ☐YES

If your practice is enrolling in the NCMS Plan before your current plan is scheduled to expire, are you requesting credit for employee deductibles met under the prior plan? ☐NO ☐YES

Would you like to schedule a free consultation with the NCMS Plan's Manager of Health Promotion & Well-Being to discuss ways to improve the health of your employees and help control claim costs? ☐NO ☐YES

Marketed exclusively by SRA Benefits Consulting

PROBATIONARY PERIOD

☐0 True (coverage effective on first day of employment)
☐30 Days (coverage effective on 1st of month following completion of 30 days of employment)
☐60 Days (coverage effective on 1st of month following completion of 60 days of employment)
☐90 True (coverage effective on date following 90 days of employment)

EMPLOYEE COVERAGE TERMINATION DATE FOR HEALTH INSURANCE

☐End of Month following employment termination
☐Last day of employment

PRIOR CARRIER AND RATE INFORMATION

Please provide health insurance carrier history for the last three (3) years (required):

CARRIER #1	EFFECTIVE PERIOD	REASON FOR LEAVING
CARRIER #2	EFFECTIVE PERIOD	REASON FOR LEAVING
CARRIER #3	EFFECTIVE PERIOD	REASON FOR LEAVING

Please provide current and renewal rates with current plan summary (required):

	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD	EMPLOYEE/CHILDREN	FAMILY
CURRENT RATES					
RENEWAL RATES					

EMPLOYER'S CONTRIBUTION

What is the employer's contribution to the cost of the health care program? (minimum contribution toward employee cost is 50%)

Employee coverage _____% Dependent coverage _____% or Fixed: Employees $_____ Dependents $_____

ELIGIBILITY CRITERIA

Full-Time Employee Definition: ☐Work 30 or more hours per week ☐Work 24 or more hours per week

Retiree Coverage (Physician and Non-physician) [1]: ☐YES ☐NO

Surviving Spouse of Physician Coverage [1]: ☐YES ☐NO

Spouse of Retiree Coverage (Physician and Non-physician) [1, 2]: ☐YES ☐NO

1 Requires employer's ongoing participation in the NCMS Plan. 2 Requires the employer to offer Retiree Coverage.

CENSUS INFORMATION

Full-time employees (as defined in Eligibility Criteria) include Physicians and Non-Physicians. 75% participation is required of FTEs, less eligible waivers for Other Group Coverage. Each employee rejecting coverage must complete a Declination of Coverage form.

	Number of FTEs	FTEs Electing Coverage	FTEs Rejecting Coverage	A. On Other Group Coverage	B. On Individual Coverage	C. Other Rejecting Coverage
Physicians						
Non-Physicians						
Total						

HEALTH INFORMATION PROFILE

Please provide the answers to the following questions to the best of your knowledge as they pertain to all eligible employees and/or covered dependents. It is important that you include information pertaining to those members continuing through COBRA or state continuation programs.

Condition	Yes	No	Condition	Yes	No
Accidental Injury			High Risk Pregnancy		
AIDS/HIV Disease			Intestinal Malabsorption		
Alcohol or Drug Dependency or Abuse			Liver Disease		
Alpha 1 (Antitrypsin Deficiency)			Mental Disorder/Depression		
Amyloidosis			Morbid Obesity		
Anterior Horn Cell Disease			Mucopolysaccharidoses (Morquio syndrome)		
Back Disorders			Multiple Sclerosis		
Blood Disorder (Hemophilia, sickle cell, etc.)			Muscular Dystrophy		
Bronchial or Pulmonary Candidiasis			Nervous System Disorder		
Burns - Severe			Osteomyelitis		
Cancer, Leukemia, Lymphoma, Neoplasms, etc.			Pancreatitis		
Cardiomyopathy			Renal Disease		
Cerebral Vascular Disease/Stroke			Respiratory Problem		
Chronic Inflammatory Demylinating Polyneuropathy			Seizures		
Cystic Fibrosis			Septicemia		
Diabetes or High Blood Sugar			Traumatic Injury - Major (Spinal cord, head, etc.)		
Gaucher's Disease			Toxoplasmosis		
Heart/Lung Disease			Tuberculosis		
Hepatitis			Other_____		
High Blood Pressure			Other_____		

Indicate if any eligible employee or dependent,

Is currently pregnant? ☐Yes ☐No
Is scheduled for hospitalization and/or surgery? ☐Yes ☐No
Has undergone treatment for any mental or physical illness during the past two years which resulted in expenses in excess of $10,000? ☐Yes ☐No
Had had a serious job related injury in the past two years? ☐Yes ☐No
Is a potential transplant recipient? ☐Yes ☐No
Has had or is considering gastric bypass? ☐Yes ☐No
Has an implant of a heart assist device? ☐Yes ☐No

For any applicant, provide all conditions or diagnosis, treatment, medication, surgery, for all medical conditions ongoing or where treatment occurred in last three (3) years. Also include information for any YES answers above. If more space is needed, submit a separate sheet with your signature and date. Please print clearly and legibly.

	DIAGNOSIS	TREATMENT AND MEDICATIONS	LAST DATE TREATED
Applicant #1			
Applicant #2			
Applicant #3			
Applicant #4			
Applicant #5			
Applicant #6			
Applicant #7			

C. LIFE INSURANCE PROGRAM ENROLLMENT INFORMATION (Group Term Life/AD&D requires 100% full-time employee participation)

Single Flat Option (Guaranteed issue up to $50,000) □ $15,000 □ $25,000 □ $30,000 □ $50,000 □ $75,000

Dual Flat Option (EOI required for higher amount) □ $15,000 & $25,000 □ $15,000 & $30,000 □ $25,000 & $50,000

□ $30,000 & $50,000 □ $30,000 & $75,000 □ $50,000 & $75,000

Salaried Option (Guaranteed issue up to $150,000) □ 1 x salary □ 2 x salary □ 3 x salary

□ Decline Group Term Life/AD&D and Dependent Life

Dependent Life (Select one option. 100% employee participation not required, product is voluntary)

□ Spouse, $5,000; Children ages 6 months to 19 years, $2,500; Children ages 14 days to 6 months, $250

□ Spouse, $10,000; Children ages 6 months to 19 years, $5,000; Children ages 14 days to 6 months, $500

□ Decline Dependent Life

D. DENTAL INSURANCE PROGRAM ENROLLMENT INFORMATION

The NCMS Plan offers dental products underwritten by MetLife.

Will your practice offer NCMS Plan dental through MetLife? ☐YES ☐NO

If yes, you will need to complete separate applications to enroll your practice and your employees.

Applications will be provided.

I hereby certify that the information contained herein is complete and accurate to the best of my knowledge and belief. I understand that any misrepresentations or false statements will subject any issued coverage to immediate termination.

Submitted by:_____ **Date:**_____

(Signature of Authorized Employer Official)