Request for Proposal Form (Groups <16)

NCMS *North Carolina Medical Society Employee Benefit Plan*

Instructions:
Please complete Sections A through D of the form below. All fields are required for submission of your application form. Review Section E and F for additional required information to be submitted with this form.

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

GROUP ADMINISTRATOR PRIMARY CONTACT NAME | JOB TITLE

☐ DR. ☐ MR. ☐ MRS. ☐ MS.

PHONE NUMBER | FAX NUMBER | E-MAIL

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

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

B. 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.

	# of FTE's	FTE's Electing Coverage	FTE's on Other Group Coverage	FTE's on Individual Coverage	Rejecting Coverage
Physicians					
Non-Physicians					
Total:					

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

C. DESIRED COVERAGE EFFECTIVE DATE

PROPOSED START DATE FOR NCMS PLAN COVERAGE

DATE: _____

D. NCMS HEALTH PLAN REQUIREMENTS

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

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.

E. ADDITIONAL REQUIRED INFORMATION

Groups must provide a full employee census in addition to the attached form.
Census information must include: Name, Date of Birth, and Tier of Coverage (e.g., Single, Family)

F. OPTIONAL REQUESTED INFORMATION

If available, please include with your submission information about current benefits, current rates and/or renewal rates.
Optional information will ensure the most competitive proposal for NCMS Plan coverage.

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)