

New Group Application Form



Please read and complete all sections of this application.

<u>Coverage Effective Date:</u>	<u>Service Team Information</u> Client Executive:	Account Advisor:
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A. EMPLOYER INFORMATION

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. HEALTH INSURANCE PROGRAM ENROLLMENT INFORMATION

PRODUCT(S)	PPO	1000-70	1500-70	2000-80	2500-80	2500-70	2500-60	3500-80	3500-70
		3500-60	4000-70	5000-60	5000-70	7000-50	7900-100	8550-100	
	PPO 1-2-3	1500	2000	2500	3500	4000	5000	5000 (alternate Rx)	
RAF	HDHP	2700-100	2700-80	3500-100	5000-100				
		6350-100	5500-70	7000-100	7500-100	8050-100			

All employers may offer two products. Employers with more than 16 enrolled employees may select three products.

C. 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.

D. HEALTH SAVINGS ACCOUNT (HSA)

Groups electing HDHP products may offer Health Saving Accounts (HSAs) to enrolled members. The NCMS Plan partners with Health Equity for HSA administration. This service includes administrative fees paid by the NCMS Plan and allows for member data to be managed through automated feeds between BCBSNC and Health Equity.

If you choose to offer any HDHP Plan benefits, please confirm if you would like to implement Health Equity services OR if you currently use Health Equity please confirm if you'd like to convert to the NCMS Plan's integrated service.

New Health Equity Implementation Existing Health Equity Conversion

E. DENTAL INSURANCE ENROLLMENT INFORMATION

The NCMS Plan offers dental products underwritten by MetLife. An employer may select to have only one plan option (A through E) or a dual plan option of Plan A plus any other Plan (B, C, D or E). Whether you choose the one plan option or dual plan option, a minimum of 75% of eligible employees must enroll. An employer contribution of 25% is required.

Plan A w/o Ortho	Plan B w/o Ortho	Plan C w/o Ortho	Plan D w/o Ortho	Plan E w/o Ortho
	Plan B w/ Ortho	Plan C w/ Ortho	Plan D w/ Ortho	Plan E w/Ortho

Please Note: A separate MetLife enrollment form will be provided for setup of dental plan coverage.

F. LIFE INSURANCE PROGRAM ENROLLMENT INFORMATION

The NCMS Plan offers life insurance options underwritten by USABLE Life. Accidental Dental & Dismemberment (AD&D) coverage is included. Group Term Life/AD&D requires 100% full-time employee participation. Dependent Life may only be elected in combination with a Group Term Life policy.

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

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

\$30,000 & \$50,000 \$30,000 & \$75,000 \$50,000 & \$75,000

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

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

G. COBRA

Federal COBRA Continuation Law applies to employer groups that had 20 or more total employees for 50% of the business days in the preceeding calendar year. To aid groups required to offer COBRA the NCMS Plan partners with Flores for COBRA Administration services with fees paid by the NCMS Plan.

Please confirm if you require Flores setup or conversion (for existing Flores customers) as part of your NCMS Plan Implementation.

Implementation Required Conversion Required Other Carrier in Use:

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: _____
(Signature of Authorized Employer Official)

Date: _____