Request for Proposal Form (Groups 16+)

NCMS *North Carolina Medical Society Employee Benefit Plan*

Instructions:
Please complete Sections A through F of the form below. **All fields are required for submission of your application form**. Review Section G 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. HEALTH CONDITION SUMMARY

HEALTH INFORMATION PROFILE

Please fill out the chart below indicating Yes, No or Unknown for any health conditions as they apply to eligible employees and/or covered dependents. Additional details, if known, can be provided for a more accurate rating. Please include information pertaining to those members continuing through COBRA or state continuation programs.

Condition	Yes	No	Unknown	Details
AIDS/HIV Disease				
Cancer, Leukemia, Lymphoma, Neoplasm				
Circulatory Disorder				
Cystic Fibrosis				
Diabetes				
Digestive Disorder				
Heart Disease				
Hepatitis				
High Blood Pressure				
Injury - Accidental, Burns or Severe				
Liver Disease				
Lung/Pulmonary Disease				
Muskuloskeletal System Disorder				
Nervous System Disorder				
Pregnancy				
Renal Disease				
Respiratory Disease				
Seizures				
Skin Disorder				
Other				
Other				

If any eligible employee or dependent has the following circumstances please indicate the response and provide additional details in the section provided below:

	Yes	No	Unknown
Is scheduled for hospitalization and/or surgery?			
Has undergone treatment for any mental or physical illness during the past 2 years which resulted in expenses in excess of $10,000?			
Had had a serious job related injury in the past two years?			
Is a potential transplant recipient?			

Please use the space below to provide additional explanation as needed:

E. 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.

F. PRIOR CARRIER AND RATES

PRIOR CARRIER AND RATE INFORMATION

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

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

Please provide current and renewal rates with current plan summary:

	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILD	EMPLOYEE/CHILDREN	FAMILY
Plan 1 Current Rates					
Plan 2 Current Rates					
Plan 1 Renewal Rates					
Plan 2 Renewal Rates					

G. ADDITIONAL REQUESTED 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)

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)