

Employer Application and Change Form



North Carolina Medical Society Employee Benefit Plan

For NCMS Plan Use Only

Group Number: _____ RAF: _____

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
LOCATION ADDRESS (If different than Mailing Address)		CITY	STATE	ZIP CODE COUNTY
PHONE NUMBER	FAX NUMBER	E-MAIL	CONTACT PERSON <input type="checkbox"/> DR. <input type="checkbox"/> MR. <input type="checkbox"/> MS.	TITLE
PREVIOUS MEMBER OF NCMS PLAN? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, withdrawal date: _____		EMPLOYER TYPE <input type="checkbox"/> Corporation <input type="checkbox"/> S-Corporation <input type="checkbox"/> Professional Assoc. <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Other: _____		

B. HEALTH INSURANCE PROGRAM ENROLLMENT INFORMATION

PRODUCT(S) PPO 500-80 750-80 1000-80 1500-80 2000-80 2500-60 3500-80 5000-60

PPO 1-2-3 1000 1500 2000 2500 3500

HDHP 1500-100 2700-80 2700-100 3500-100 5000-100 HRA 2500-100 2700-80 2700-100 5000-100

All employers may offer two products. Employers with more than 50 enrolled employees may select three products. *If offering an HSA administered by Mellon or an HRA administered by BCBSNC, complete and submit an Employer HSA or HRA 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? Mellon Other (please name) _____

If applicable, are you offering an HRA? NO YES

If offering an HRA, who will serve as your HRA administrator?
 Blue Cross and Blue Shield of NC (BCBSNC) Other (please name) _____
 BCBSNC will only administer HRAs for practices with 50 or more enrolled employees.

Are you currently using Ceridian COBRA Services? NO YES

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

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

If your practice has more than 15 enrolled employees, would you like to use eBenefitsNow to maintain your enrollment? 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 Health Promotion Coordinator to discuss ways to improve the health of your employees and help control claim costs? NO YES

PROBATIONARY PERIOD(S)

Select one per class.

Physician:
 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)

Non-Physician:
 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)

EMPLOYER'S CONTRIBUTION

Employee _____% _____\$ Dependent _____% _____\$
 Percentage and amount per employee per month. Minimum contribution of 50% of employee cost is required.

Please read and complete all sections of this application.

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):

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

UNDERWRITING QUESTIONS

To the best of your knowledge, has any person, employee or dependent, applying for coverage sought medical attention or advice, been diagnosed with or been treated for any of the following diseases or disorders.

Disease or Disorder		Yes	No	Amount	
A.	AIDS (acquired immune deficiency syndrome) or HIV (human immunodeficiency virus)				
B.	Birth defect or deformity				
C.	Cancer, tumor, growth, enlarged lymph nodes, or any other skin disorder				
D.	Lung or respiratory disorder				
E.	Hepatitis, other liver disorder, or digestive disorder				
F.	Thyroid disorder, diabetes, or digestive disorder				
G.	Adrenal gland disorder				
H.	Blood disorder				
I.	Kidney disorder, any other urinary disorder, or genital disorder				
J.	Abnormal blood pressure, heart attack, heart murmur, any other blood, heart, or circulatory disorder				
K.	Epilepsy, nervous, mental, or emotional disorder				
L.	Have there been any medical costs over \$5,000 in the past 2 years?				
M.	Do you know of any upcoming surgery or procedure?				

EXPLANATION OF ALL APPLICANT'S HEALTH HISTORY

For any applicant, provide all conditions or diagnosis, treatment, medication, surgery, for all medical conditions ongoing or where treatment occurred in last seven (7) years. Also include information for any YES answers above. If more space is needed, submit a separate sheet with your signature and date.

	Date of Birth	Condition	Date of Onset	Date Last Treated	Details of Treatment
Applicant #1					
Applicant #2					
Applicant #3					
Applicant #4					
Applicant #5					
Applicant #6					
Applicant #7					

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						

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

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

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. These 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: _____
(Authorized Representative of Employer)

Date: _____