



North Carolina Medical Society Employee Benefit Plan
 P.O. Box 97968 Raleigh, NC 27624
 Fax: 919-878-7590

EMPLOYER DENTAL APPLICATION/CHANGE FORM
(Please Type or Print)

MMIC Agency Use Only Division: _____ Agent: _____

SECTION 1. EMPLOYER INFORMATION

Employer Name: _____
(Provide Complete Legal Name)

FEIN: _____ - _____ Medical Specialty: _____
(Federal Employer Identification Number)

Employer Type: Corporation S-Corporation Partnership
(Select One) Professional Assoc. LLC Other: _____

Location Address: _____ Mailing Address *(If different from Location Address):* _____

(City, State, Zip) (County) (City, State, Zip)

Contact Person: _____ Telephone Number: (____) _____ - _____
 Dr. Mr. Ms. *(Name, Title)*

FAX Number: (____) _____ - _____ E-Mail Address: _____

Previous Member of NCMS Plan: Yes No If "Yes", Withdrawal Date: _____

SECTION 2. DENTAL ENROLLMENT INFORMATION

Plan (Employer may select two (2) plans. If two plans offered, one plan **must** be Plan A):

- Plan A (\$1,000 maximum) *(Orthodontia not available)*
- Plan B (\$1,250 maximum) with Orthodontia without Orthodontia
- Plan C (\$1,500 maximum) with Orthodontia without Orthodontia
- Plan D (\$1,500 maximum) with Orthodontia without Orthodontia

Proposed Coverage Effective Date: _____ Prior Carrier (if any): _____
(Attach a copy of most recent billing statement)

Probationary Period (select one per class):

- Physician: 0 True 30 Days* 60 Days* 90 True
- Non-Physician: 0 True 30 Days* 60 Days* 90 True

* to take effect the 1st of the subsequent month following Probationary Period completion

Employer Contribution (of employee cost):
 minimum 25% other _____%

Employer Contribution (of dependent cost):
 none other _____%

SECTION 3. METLINK USER AUTHORIZATION INFORMATION (use additional sheets if necessary)

User No. 1

User No. 2

First, Last Name:

Business Address:

City, State, ZIP:

Business Email:

Business Phone:

The following MetLink features will be assigned to all users:

- Enrollment / Eligibility – Update and Inquiry
- Resources (User Guide & Legislative releases)
- On Line List Billing
- Dental Claims Inquiry

Please note: MetLife dental customers must comply with all HIPAA requirements as well as become certified with MetLife in order to obtain access to the Dental Claim Inquiry feature of MetLink.

CUSTOMER SIGNATURE TO AUTHORIZE MMIC AGENCY ACCESS: _____

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.

Signed: _____
(Authorized Representative of Employer)

Date: _____