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

MMIC Agency Use Only
Division:_______________
Agent:_________________

EMPLOYER DENTAL APPLICATION/CHANGE FORM

(Please Type or Print)

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
☐ Plan E ($5,000 maximum)	☐ with Orthodontia	☐ without Orthodontia

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

Probationary Period:
☐ 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: ____ Date: ______________
(Authorized Representative of Employer)

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