

# Employer Application and Change Form



## North Carolina Medical Society Employee Benefit Plan

Please read and complete all sections of this application.

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
PHYSICAL ADDRESS (If different than Mailing Address)		CITY	STATE	ZIP CODE COUNTY
PHONE NUMBER	FAX NUMBER	E-MAIL	GROUP ADMINISTRATOR	<input type="checkbox"/> DR. <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <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: _____		
DO ANY ELIGIBLE EMPLOYEES RESIDE OUTSIDE THE STATE OF NORTH CAROLINA? <input type="checkbox"/> NO <input type="checkbox"/> YES		If YES, list states: _____		

### B. HEALTH INSURANCE PROGRAM ENROLLMENT INFORMATION

<b>PRODUCT(S)</b>	<b>PPO</b>	<input type="checkbox"/> 1000-70	<input type="checkbox"/> 1500-70	<input type="checkbox"/> 2000-80	<input type="checkbox"/> 2000-70	<input type="checkbox"/> 2500-80	<input type="checkbox"/> 2500-70	
		<input type="checkbox"/> 3500-80	<input type="checkbox"/> 3500-70	<input type="checkbox"/> 5000-60	<input type="checkbox"/> 2500-60	<input type="checkbox"/> 3500-60		
	<b>PPO VALUE</b>	<input type="checkbox"/> 2000-70	<input type="checkbox"/> 2500-70	<input type="checkbox"/> 3500-70	<input type="checkbox"/> 2500-60	<input type="checkbox"/> 3500-60	<b>PPO ESSENTIAL</b>	<input type="checkbox"/> 7900-100
	<b>PPO 1-2-3</b>	<input type="checkbox"/> 1500	<input type="checkbox"/> 2000	<input type="checkbox"/> 2500	<input type="checkbox"/> 3500	<input type="checkbox"/> 4000	<input type="checkbox"/> 5000	<input type="checkbox"/> 5000 (alternate Rx)
	<b>HDHP</b>	<input type="checkbox"/> 2700-80	<input type="checkbox"/> 2700-100	<input type="checkbox"/> 3500-100	<input type="checkbox"/> 5000-100	<b>HDHP VALUE</b>	<input type="checkbox"/> 2700-100	<input type="checkbox"/> 3500-100
		<input type="checkbox"/> 6350-100	<input type="checkbox"/> 5500-70	<input type="checkbox"/> 7000-100				

All employers may offer two products. Employers with more than 50 enrolled employees may select three products. Value plans are only suitable in certain counties. Review with your Benefits Consultant before electing. If offering an HSA administered by HealthEquity, complete and submit an Employer HSA 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? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If offering an HSA, who will serve as your HSA administrator? <input type="checkbox"/> HealthEquity <input type="checkbox"/> Other (please name) _____	
Are you currently using Flores COBRA Services? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If no and your practice is subject to COBRA, would you like Flores to administer COBRA for you? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If currently on a BCBSNC direct plan, are you using eBenefitsNow to maintain your enrollment? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If your practice has more than 15 enrolled employees, would you like to use eBenefitsNow to maintain your enrollment? <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Would you like to schedule a free consultation with the NCMS Plan's Manager of Health Strategy & Well-Being to discuss ways to improve the health of your employees and help control claim costs? <input type="checkbox"/> NO <input type="checkbox"/> YES	

### 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) <sup>1</sup>:  YES  NO

Surviving Spouse of Physician Coverage <sup>1</sup>:  YES  NO

Spouse of Retiree Coverage (Physician and Non-physician) <sup>1,2</sup>:  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: \_\_\_\_\_  
(Signature of Authorized Employer Official)

Date: \_\_\_\_\_