Employer Application and Change Form

NCMS *North Carolina Medical Society Employee Benefit Plan*

For NCMS Plan Use Only

Group Number:_____ RAF:_____

Please read and complete all sections of this application.

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 ☐DR. ☐MR. ☐MRS. ☐MS. | TITLE

PREVIOUS MEMBER OF NCMS PLAN? ☐NO ☐YES If YES, withdrawal date:_____

EMPLOYER TYPE ☐Corporation ☐S-Corporation ☐Professional Assoc. ☐LLC ☐Partnership ☐Other:_____

DO ANY ELIGIBLE EMPLOYEES RESIDE OUTSIDE THE STATE OF NORTH CAROLINA? ☐NO ☐YES If YES, list states:_____

B. HEALTH INSURANCE PROGRAM ENROLLMENT INFORMATION

PRODUCT(S)

PPO	☐1000-70 ☐1500-70 ☐2000-80 ☐2000-70 ☐2500-80 ☐2500-70 ☐2500-60 ☐3500-80 ☐3500-70 ☐3500-60 ☐4000-70 ☐5000-60 ☐5000-70 ☐6000-60 ☐7900-100
PPO 1-2-3	☐1500 ☐2000 ☐2500 ☐3500 ☐4000 ☐5000 ☐5000 (alternate Rx)
HDHP	☐2700-100 ☐2700-80 ☐3500-100 ☐3500-70 ☐5000-100 ☐6350-100 ☐5500-70 ☐7000-100 ☐8550-100

All employers may offer two products. Employers with more than 16 enrolled employees may select three products. *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? ☐NO ☐YES

If offering an HSA, who will serve as your HSA administrator? ☐HealthEquity ☐Other (please name)_____

Are you currently using Flores COBRA Services? ☐NO ☐YES

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

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

Does your practice use an automated file feed or third party vendor to transmit enrollment data to your ☐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 Manager of Health Promotion & Well-Being to discuss ways to improve the health of your employees and help control claim costs? ☐NO ☐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

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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.

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 (Guaranteed issue up to $50,000) □ $15,000 □ $25,000 □ $30,000 □ $50,000 □ $75,000

Dual Flat Option (EOI required for higher amount) □ $15,000 & $25,000 □ $15,000 & $30,000 □ $25,000 & $50,000 □ $30,000 & $50,000 □ $30,000 & $75,000 □ $50,000 & $75,000

Salaried Option (Guaranteed issue up to $150,000) □ 1 x salary □ 2 x salary □ 3 x salary

□ 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:_____ **Date:**_____

(Signature of Authorized Employer Official)