

Adoption Agreement

SCMA Members' Insurance Trust

P.O. Box 11188 Columbia, SC 29211

phone (803) 798-6207 fax (803) 731-4021



Requested Effective Date

Requested Effective Date of Health Coverage

Requested Effective Date of Dental Coverage

Group Information

Group Name		Tax ID Number
Group Address	City/State/Zip	County
Phone Number	Fax Number	Contact Email Address
Business is a <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other	If Other, Please Explain	
Will Employer Contribute 100% of Employee Cost? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, What Percent Will Employer Contribute? <i>*PLEASE NOTE: The employer must contribute a minimum of 50% of the employee cost.</i>	
Total Number of Employees <i>*50% participation is required.</i>	Number of Full Time Employees	Number of Part Time Employees
Probationary Period for Physicians to Be Covered <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 1st day of the month following date of hire	Probationary Period for Employees to Be Covered <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 1st day of the month following date of hire	
Current Group Health Plan Name	Current Group Health Plan Address	City/State/Zip
Effective Date	Termination Date	

Plan Selection(s) Limited to Three (3) Plan Design Options

Preferred Plans	Major Medical Plans	High Deductible Health Plans	
<input type="checkbox"/> Premier <input type="checkbox"/> Prime <input type="checkbox"/> Select <input type="checkbox"/> Essential <input type="checkbox"/> Premier Plus <input type="checkbox"/> Prime Plus <input type="checkbox"/> Select Plus <input type="checkbox"/> Essential Plus	Choice Plus <input type="checkbox"/> Major Medical Only <input type="checkbox"/> Enhanced Package HD \$1,000 <input type="checkbox"/> Major Medical Only <input type="checkbox"/> Enhanced Package HD \$1,500 <input type="checkbox"/> Major Medical Only <input type="checkbox"/> Enhanced Package	HD \$2,000 <input type="checkbox"/> Major Medical Only <input type="checkbox"/> Enhanced Package HD \$3,000 <input type="checkbox"/> Major Medical Only <input type="checkbox"/> Enhanced Package HD \$5,000 <input type="checkbox"/> Major Medical Only <input type="checkbox"/> Enhanced Package	<input type="checkbox"/> HDHP I <input type="checkbox"/> HDHP II <input type="checkbox"/> HDHP III <input type="checkbox"/> HDHP IV <input type="checkbox"/> HDHP V <input type="checkbox"/> HDHP VI

Required Information

Are there any classes of employees other than part-time employees to be excluded from participation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Which Ones?	
Will everyone covered by your group have Workers' Compensation Coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any employees or dependents currently disabled or not actively at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any employees or dependents currently covered by or eligible for any state or COBRA Continuation of Coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Attach a copy of the most recent quarterly tax and wage statement and a recent billing statement from your current carrier.	

PLEASE READ CAREFULLY BEFORE SIGNING

The undersigned Employer, by executing this Adoption Agreement, elects to become an Adopting Employer in the South Carolina Medical Association Voluntary Employees' Members' Association Welfare Benefit Plan subject to the conditions listed above.

Termination of coverage: I agree to notify SCMA/MIT in writing at least 30 days prior to terminating group coverage or within 10 days of termination of any individual covered employee. I agree to reimburse the SCMA/MIT any amounts paid for claims incurred and/or prescriptions purchased after the date coverage ends.

It is understood and agreed that SCMA/MIT does not assume the Employer's responsibilities for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or any other legal obligations of the Employer.

I acknowledge the information provided on this form is accurate and complete.

I understand that additional information may be requested in order to verify eligibility.

Practice Name	Date
Signature	Printed Name & Title
Office Use Only	
SCMA Representative	Tier