



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
[] Professional Assoc. [] LLC [] Other: _____
(Select One)

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 (select one):
[] 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 On Line List Billing
Resources (User Guide & Legislative releases) 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)