Quote Request Form

North Carolina Medical Society
Employee Benefit Plan

Please type or print. Asterik (*) denotes required information. Quotes presented will be based on rates effective as of the Coverage Effective Date.

A. EMPLOYER INFORMATION

EMPLOYER NAME* (Provide complete legal name)			SPECIALTY*	
LOCATION ADDRESS*	CITY	STATE	ZIP CODE	COUNTY*
MAILING ADDRESS (If different than Location Address)	CITY	STATE	ZIP CODE	COUNTY
PHONE NUMBER*	FAX NUMBER	E-MAIL	CONTACT PERSON* ☐DR. ☐MR. ☐MS.	TITLE
COVERAGE EFFECTIVE DATE*	CURRENT CARRIER	RENEWAL DATE	REFERRAL SOURCE	

B. HEALTH PRODUCTS

Select the health product(s) you would like quoted.

☐PPO 500-80 ☐PPO 750-80 ☐PPO 1000-80 ☐PPO 1500-80
☐PPO 2000-80 ☐PPO 2500-60 ☐PPO 3500-80 ☐PPO 5000-60

☐HDHP 1500-100 ☐HDHP 2700-80 ☐HDHP 2700-100
☐HRA 2500-100 ☐HRA 2700-80 ☐HRA 2700-100

The NCMS Plan offers other employee benefit programs with a variety of options. Please indicate whether you would like more information about these products: **Life/AD&D Insurance** ☐YES ☐NO **Dental Insurance** ☐YES ☐NO

C. CENSUS INFORMATION (duplicate and attach additional sheets if necessary)

EMPLOYEE NAME* (First and Last)	**DATE OF BIRTH***	**COVERAGE TYPE*** **(Check all that apply)**
		☐Employee ☐Spouse ☐Child ☐Children
		☐Employee ☐Spouse ☐Child ☐Children
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Submitted by:_____ **Date:**_____

(Authorized Representative of MMIC Agency, Inc.)

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