

ADOPTION AGREEMENT

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 below.

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.

IF REQUESTING INDIVIDUAL COVERAGE ONLY COMPLETE #'s 1 AND 3

1. Requested Effective Date of Health Coverage _____
Requested Effective Date of Dental Coverage _____

2. Group Name: _____
Group Address: _____

Telephone #: _____ Fax #: _____
Number of Years in Business: _____ Administrator: _____
Is Business a: Professional Corporation Partnership Sole Proprietorship
Will employer Contribute 100% of Employee Cost? yes no If no, what percent: _____
Number of employees requesting health insurance: _____
Employer's probationary period prior to health insurance eligibility: _____

3. Current Group Health Plan Name/Address: _____
Effective date: _____ Termination date: _____
Deductible: _____ Coinsurance %: _____
Max. out of pocket: _____ PPO Network: _____
Physician Office Copay: _____ Drug Card Copay: _____
Life Insurance _____ AD&D _____
Dental _____ STD _____
LTD _____ Rates _____

4. Are there any classes of employees (other than part-time employees) to be excluded from participation? Yes No If yes, which ones? _____
5. Please attach a copy of the most recent billing statement from your current carrier.
6. Will everyone covered by your group have Workers' Compensation coverage? Yes No
7. Are any employees or dependents currently disabled or not actively at work? Yes No
8. Are any employees or dependents currently covered by or eligible for any state or COBRA Continuation of Coverage? Yes No
9. Please provide details for any of the following questions answered YES in the space provided below.
- Have any employees or dependents incurred claims in excess of \$15,000 in the last six months?
 - Have any employees or dependents been rejected for health reasons, or had coverage ridered within the last three years?
 - Have any employees, dependents, or anticipated dependents consulted or been treated by a physician or medical facility for surgery, serious injury or health problems such as AIDS, cancer, diabetes, heart or circulatory, digestive, respiratory, mental, nervous, or substance abuse problems? _____
10. Are any employees covered under your current group plan pregnant? Yes No

It is understood and agreed that MIT or SCMA 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.

Dated this _____ day of _____ 20_____.

Practice Name: _____

Signature: _____ Title: _____ Date _____

Office use only Standard rates Rate Up

SCMA Representative _____