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 ❑ Professional Corporation ❑ Partnership ❑ Sole Proprietorship ❑ Other		**If Other, Please Explain**
Will Employer Contribute 100% of Employee Cost? ❑ Yes ❑ No	**If No, What Percent Will Employer Contribute?** **PLEASE NOTE: The employer must contribute a minimum of 50% of the employee cost.*	
Total Number of Employees **50% participation is required.*	**Number of Full Time Employees**	**Number of Part Time Employees**

Probationary Period for Physicians to Be Covered	Probationary Period for Employees to Be Covered
❑ 0 days ❑ 30 days ❑ 60 days ❑ 90 days ❑ 1st day of the month following date of hire	❑ 0 days ❑ 30 days ❑ 60 days ❑ 90 days ❑ 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

- ❑ **Premier**
- ❑ **Prime**
- ❑ **Select**
- ❑ **Essential**

Major Medical Plans

Choice Plus
- ❑ Major Medical Only
- ❑ Enhanced Package

HD $1,000
- ❑ Major Medical Only
- ❑ Enhanced Package

HD $1,500
- ❑ Major Medical Only
- ❑ Enhanced Package

HD $2,000
- ❑ Major Medical Only
- ❑ Enhanced Package

HD $3,000
- ❑ Major Medical Only
- ❑ Enhanced Package

HD $5,000
- ❑ Major Medical Only
- ❑ Enhanced Package

High Deductible Health Plans

- ❑ **HDHP I**
- ❑ **HDHP II**
- ❑ **HDHP III**
- ❑ **HDHP IV**
- ❑ **HDHP V**
- ❑ **HDHP VI**

Required Information

Are there any classes of employees other than part-time employees to be excluded from participation?	❑ Yes ❑ No
If Yes, Which Ones?	
Will everyone covered by your group have Workers' Compensation Coverage?	❑ Yes ❑ No
Are any employees or dependents currently disabled or not actively at work?	❑ Yes ❑ No
Are any employees or dependents currently covered by or eligible for any state or COBRA Continuation of Coverage?	❑ Yes ❑ No

❑ Attach a copy of the most recent quarterly tax and wage statement and a recent billing statement from your current carrier.

Acknowledgement *Signature required.*

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