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		
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?
Total Number of Employees	Number of Full Time Employees	Number of Part Time Employees

Probationary Period for Physicians to Be Covered ❑ 0 days ❑ 30 days ❑ 60 days	Probationary Period for Employees to Be Covered ❑ 0 days ❑ 30 days ❑ 60 days

Current Group Health Plan Name	Current Group Health Plan Address	City/State/Zip

Effective Date	Termination Date

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
Are any employees covered under your current group plan pregnant?	❑ Yes ❑ No
Have any employees or dependents incurred claims in excess of $15,000 in the last six months?	❑ Yes ❑ No
If Yes, Provide Details	
Have any employees or dependents been rejected for health reasons, or had coverage ridered within the last three years?	❑ Yes ❑ No
If Yes, Provide Details	
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?	❑ Yes ❑ No
If Yes, Provide Details	
❑ 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 eligibilty.

Practice Name	Date
Signature	Printed Name & Title

Office Use Only

SCMA Representative	❑ Standard Rates	❑ Rate Up	Percentage