



State of North Carolina Office of the State Controller

Michael F. Easley, Governor

Robert L. Powell, State Controller

January 20, 2005

MEMORANDUM NO. PR2005-002

TO: All Agencies Served by the State Controller's Office
Payroll Section

FROM: Roger Farmer
Payroll Administrator

SUBJECT: ASI TRICARE Agency Information Forms

Please find three pages which need to be filled out with the requested information pertinent for your agency. These forms should be completed and **immediately faxed** to Ms. Pauline Marshall. The contact information for Ms. Marshall has been listed below.

Ms. Pauline Marshall, Director
Corporate Accounts
Association & Society Insurance Corporation
656 Quince Orchard Road
Gaithersburg, MD 20878

TELEPHONE:
VOICE (800) 638-2610 Ext. 113
FAX (301) 816-1171 / (800) 311-3126

MAILING ADDRESS
1410 Mail Service Center
Raleigh, NC 27699-1410

Telephone: (919) 981-5454
Fax Number: (919) 981-5567
State Courier: 56-50-10
Website: www.ncosc.net/OSC/

LOCATION
3512 Bush Street
Raleigh, NC

STATE OF NORTH CAROLINA
ASI TRICARE Supplement Program

ITEMS REQUIRING REVIEW (Complete and Return by fax (301-816-1171) to Pauline Marshall)		
Address for State of North Carolina:		
Monthly Premium Rates: Plan Code: 448.2	Three-tier Employee \$60.50 Employee + Child(ren) \$119.50 Employee + Family \$160.50	<input type="checkbox"/> Confirmed <input type="checkbox"/> Not Confirmed (If a change in tier is required, please contact Pauline Marshall 800-638-2610 x 113)
State of North Carolina Has How Many Employees? Approximately How Many are Retired Military?		
Effective Date of Coverage:		
Yearly Open Enrollment Period:		
Eligibility Reporting Method:	a) Enrollment Forms b) Membership/ Eligibility File	a) <input type="checkbox"/> b) <input type="checkbox"/>
Method of Premium Payment:	Payment by Physical check Mailed to ASI Payment by wire to ASI's checking account (Account Information Required)	a) <input type="checkbox"/> b) <input type="checkbox"/>
Will Employer Pay 100% of Premium? If not, what percentage will be Paid?		
Premium Billing Contact: Include billing address if different from corporate office address	Name: Telephone: Fax: Email Address:	
Enrollment Contact: Include if different from the Premium Billing Contact.	Name: Telephone: Fax: Email Address:	

✓ I certify that I have reviewed the information above for the 2005 Plan Year.

_____ <i>Employer Representative Name (Please Print)</i>	_____ <i>Title</i>	_____ <i>Telephone Number</i>
_____ <i>Signature</i>	_____ <i>Date</i>	

STATE OF NORTH CAROLINA
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When will New Employees be Eligible for Coverage?	a) Hire Date. Or 1 st of the month following b) 30 days, c) 60 days d) 90 days Of continuous employment.	a) <input type="checkbox"/> b) <input type="checkbox"/> c) <input type="checkbox"/> d) <input type="checkbox"/>
Method of Termination:	a) Employees who terminate coverage are covered for the entire month in which termination occurs. b) Employer follows the 15/16 Rule of termination.	a) <input type="checkbox"/> b) <input type="checkbox"/>
Will Coverage Continue for Spouse and Dependents if the employee is not eligible (see page 5 under Age Termination)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Will COBRA be offered to terminating employees or should employees contact ASI for portability information?	Yes <input type="checkbox"/> COBRA will be offered No <input type="checkbox"/> COBRA will not be offered; employees can contact ASI	
If employees contact ASI for portability information, is it OK to discuss the monthly portability premium rates with them?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Select Method of Billing:	a) List Bill <input type="checkbox"/> Bills on ASI's secure web site b) Self Bill <input type="checkbox"/>	
Time Frame for Premium Payment: Premium is due from the 1 st to the 30 th of the month.	Our insurance company, The Hartford, has given us a 30-day grace period in which premium payments should be made. If a premium payment is not made within that time-frame given, each employee's coverage will automatically lapse.	
By What Date Will State of North Carolina Expect to make Monthly premium payment?		

✓ I certify that I have reviewed the information above for the 2005 Plan Year.

Employer Representative Name (Please Print)

Title

Telephone Number

Signature

Date

STATE OF NORTH CAROLINA
ASI TRICARE Supplement Program

Data Format & Transmission:

	If your company will not use the new HIPAA 834 format, please select your format of transmission below.	
<p>Will Your Company Use the New HIPAA 834 Format to Transmit Membership/Enrollment Data?</p> <p>IT Contact for testing and transmission is on the on page 15.</p>	<p>Via U.S. Postal Service on CD-ROM or Floppy Disk</p> <p>FTP via Encrypted PGP</p> <p>EMAIL via Encrypted PGP</p> <p>FTP Encrypted via</p> <p>EMAIL Encrypted via</p> <p>HTTPS via upload link from ASI's web site</p>	<p>a) <input type="checkbox"/></p> <p>b) <input type="checkbox"/> Version of PGP</p> <p>c) <input type="checkbox"/> Version of PGP</p> <p>d) <input type="checkbox"/> Encryption Software name and version</p> <p>e) <input type="checkbox"/> Encryption Software name and version</p> <p>f) <input type="checkbox"/> ASI's Preference (Quick & Easy Process)</p>
<p>If Your Company will not Use the HIPAA 834 Format, Do You have a Proprietary File Format You would like ASI to Test?</p>	<p>a) Yes</p> <p>b) No</p>	<p>a) <input type="checkbox"/> If "Yes," please send the file layout specification along with a sample test file to ASI. Proceed to file layout below.</p> <p>b) <input type="checkbox"/> If "No," and you will not use enrollment forms, please tell us how you plan to relay enrollment information to ASI.</p>

✓ I certify that I have reviewed the information above for the 2005 Plan Year.

Employer Representative Name (Please Print) Title Telephone Number

Signature Date