CREBP-NORBAR Benefit Package with Anthem BlueCross, Mutual of Omaha, Principal Dental Access Plan and Vision Plan of America

Member/Applicant: _____

Local REALTOR® Association Name: _____

Member Email Address: _____

Requested Effective Date of Coverage: _____

Network Selection: _____ **Plan Name:** _____

Plan Code: _____

Qualifying Event: _____ **Qualifying Event Date:** _____

Instructions: Complete the section for the plan above (including Network and Plan Code). Before selecting a plan change, refer to the SOB (Summary of Benefits) or SBC and consult with an agent.

CREBP Member Plan Options

	Prudent Buyer/ Select PPO Small Group Network Plans	California Care/Select HMO Small Group
Anthem Platinum	8V64– PPO 5/200/15% 94HX – PPO 15/40/10% 8V6N – PPO 15/250/10% 8VEN - PPO Plus 20 8V63 – Select PPO 5/200/15% 8ZWZ – Select PPO 15/10% 94HV – Select PPO 15/40/10% 8V6M – Select PPO 15/250/10% 8VEU - Select PPO Plus 20	901E – HMO 20 901W – HMO 25 902M – HMO 30 901D – Select HMO 20 901V – Select HMO 25 902K – Select HMO 30
Anthem Gold	8V7T – PPO 5/1500/30% 94J8 – PPO 25/30% 94JT – PPO 30/500/20% 8V70 – PPO 30/750/20% 8V5C – PPO 35/500/25% 8V7B – PPO 35/1000/20% 8VEP – PPO Plus 10/1500 8VEK – PPO Plus 25/1000 8VEL – PPO Plus 30 8V7R– Select PPO 5/1500/30% 94J9 – Select PPO 25/30% 8ZX4 – Select PPO 25/350/20% 94JV – Select PPO 30/500/20% 8V7A – Select PPO 35/1000/20% 8VET – Select PPO Plus 10/1500 8VEV – Select PPO Plus 25/1000 8VER – Select PPO Plus 30 8V71 – Select PPO 30/750/20% 8V5D – Select PPO 35/500/25% 8vBM/8VBL (Ind./Family) – PPO 1900/3400/3800 15% w/HSA - PrevRx 8VBK/8VBJ (Ind./Family) – Select PPO 1900/3400/3800 15% w/HSA - PrevRx	903C – HMO 30 903R – HMO 35 904G – HMO 35/500/20% 904W – HMO 35/1250/20% 903A – Select HMO 30 903T – Select HMO 35 904F – Select HMO 35/500/20% 904Y – Select HMO 35/1250/20%
Anthem Silver	8V87 – PPO 45/1750/40% 8V9F – PPO 50/2200/40% 8V91 – PPO 55/1950/35% 8V9X – PPO 55/2500/45% 8VEQ - PPO Plus 50/3200 8V88 – Select PPO 45/1750/40% 8V9H – Select PPO 50/2200/40% 8ZXD – Select PPO 55/2500/35% 8V8Z – Select PPO 55/1950/35% 8V9W – Select PPO 55/2500/45% 8VEW - Select PPO Plus 20/3200 8VCR/8VCS (Ind./Family) – PPO 2300/30% w/HSA - PrevRX 8VC4/8VC5 (Ind./Family) – PPO 2600/35% w/HSA - PrevRX 8VCG/8VCF(Ind./Family) – Select PPO 2300/30% w/HSA - PrevRx 8VD1/8VD2 (Ind./Family) – Select PPO 2600/35% w/HSA - PrevRx	94K7 – HMO 55 94KJ – HMO 60/2500/45% 94K8 – Select HMO 55 94KK – Select HMO 60/2500/45%
Anthem Bronze	8VDB – PPO 4600/50% 8VAN – PPO 40/6200/40% 8VAZ – PPO 60/6850/40% 8VB9 – PPO 70/6600/35% 8VAC – PPO 75/7300/40% 8VDP – PPO 6000/45% w/HSA - PrevRx 8VE4 – PPO 6700/0% w/HSA - PrevRx 8VDJ – Select PPO 4600/50% 8VAP – Select PPO 40/6200/40% 8VAY – Select PPO 60/6850/40% 8VB8 – Select PPO 70/6600/35% 8VAB – Select PPO 75/7300/40% 8VDU – Select PPO 6000/45% w/HSA - PrevRx 8VE9 – Select PPO 6700/0% w/HSA - PrevRx 8ZXN – Select PPO 7200/0% w/HSA	**Vivity HMO Small Group Network Plans** 8ZXY – Anthem Platinum HMO 15 8ZYJ – Anthem Gold HMO 25 8ZYZ – Anthem Gold HMO 25/500 900A - Anthem Gold HMO 35/1000 8ZZY - Anthem Gold HMO 35/1850

ELIGIBILITY REQUIREMENT - In all cases, membership in a Local Realtor Association must be in effect to enroll, the membership must be maintained in order to preserve eligibility. Failure of either of these basic eligibility criteria will result in termination of coverage. Periodic audits are performed to confirm continuous Local Realtor Association membership.

Application Instructions

Please Type or Print Clearly using only Black Ink

***CREBP is a special benefit package available to both Affiliate and Realtor members of Local Realtor Associations. Please be advised that your Association, The Benefits Store, Inc. and their agents do not control premiums or coverage benefits provided by these plans. Rates as shown are inclusive of premiums and administration for Health/Medical, Mutual of Omaha Life Insurance with AD&D, New Dental Choice and Vision (included in certain plans). Plans are administered by The Benefits Store Insurance Services**

Enrollment / Instructions

California Local Realtor Association Benefits

Effective Date of Coverage: Applications must be received in our office by the **20th** of the month prior to the effective date. You should not cancel your current coverage until you are notified of your new coverage.

Application Process Time Schedule:

- Please keep a copy of your enrollment form which serves as your temporary Anthem Blue Cross Member ID until you receive your official member ID card.
- Anthem Data Base - allow 12 business days from our receipt and processing of your enrollment
- Anthem ID Cards – allow 15 business days from our receipt and processing of your enrollment.

Applications may be sent to The Benefits Store or directly to your agent:

- Emailed to Operations@BenefitsStore.com
- Faxed to **925-855-2051**
- Mailed to: The Benefits Store - PO Box 238, Alamo CA 94507

If you send the application via email – make sure the file is encrypted to protect your HIPAA information, or ask your agent or The Benefits Store to send a secure document request.

Payment: Premium payment must be received with the application. You have options.

- Include a check for the first month's premium – make payable to **The Benefits Store Trust Account**
- Complete the CCA Payment section of the payment form (included)
- Complete the EFT/ACH Payment section of the payment form (included)

Both the CCA and EFT/ACH payment form allow for the option to set up recurring automatic monthly payments.

Monthly Premium Billing and Payment

- Premium Billing is in advance, on the 1st of each month for the following month's premium
- Premium Payment is due on the 20th of the billing month, in advance of the following month's coverage
- Example**:** You will receive July's invoice on the 1st of June – premium payment is due by June 20th for July's coverage.

Cancellation of Coverage: To cancel your coverage or revoke your application, we require a notice of your intent to be faxed to **925-855-2051** or emailed to Operations@BenefitsStore.com.

By signing your enrollment application, you represent that all the information you have included is complete and accurate, and that you accept all terms of CREBPT eligibility guidelines.

Acknowledgement Signature:_____ Date: _____

CREBP MEMBER BENEFITS

Your California Real Estate Benefit Plan (CREBP) provides added value and protection

Enhanced Benefits

These Extra Benefits Are Included With Your CREBPT Kaiser Insurance!

- **$10,000 life insurance**
- **$50,000 AD&D insurance**
- **Special Discounted Dental Benefits**
- **Vision Plan of America**

Please Read Below for more information.

Anthem BlueCross

Principal®

Mutual of Omaha

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Enhanced Benefits Included

Special Discount Dental Plan

- The Principal Special Discount Plan gives you immediate, predictable and significant discounts of up to 60% for dental services. Plan members decide when to use a participating dentist, how often, and without any limit on their savings.
- Principal contracts with thousands of general dentists and specialists. *You can even choose to nominate your dentist! Feel confident, you have one of the largest, credentialed networks at your service.*

$10,000 Voluntary Life

- You automatically have a $10,000 Life Insurance policy through Mutual of Omaha Life Insurance Company included with your CREBP Kaiser Permanente Medical Plans. This special life insurance benefit covers the primary insured member only, is guaranteed issue without any exclusion for medical conditions and includes AD&D benefits.
- ***You have additional opportunities to add more coverage for yourself, and your family members.***

$50,000 AD&D Coverage

- You automatically have $50,000 of AD&D Insurance coverage through Mutual of Omaha Life Insurance Company included in your CREBP Kaiser Permanente Medical Plans. This special AD&D coverage benefit covers the primary insured member only, is guaranteed issue without exclusion.
- ***For only pennies, you have additional opportunities to add more coverage for yourself, and your family members. Please don't miss this.***

Vision Plan of America

- You automatically have Vision Plan of Americas basic co-payment vision plan M-PLUS, offering unlimited benefits. One of our strengths is the ability to customize a vision plan to meet the needs of our clients. This schedule of benefits is a standard example of a Co-Payment Vision Plan.
- ***You have additional opportunities to upgrade your Vision Benefit Plan.***

Principal® Dental Access Plan

We invite you to join the thousands of smiling Principal® Dental Access Plan members to save

Principal® Dental Access Plan give you the power to decide when to visit the qualified dentist and how often. There are no limitations on visits and how much you can save. Your membership offers you access to savings on all services, from routine checkups to major treatments. With Principal® Dental Access Plan you only pay for the services you need.

Who's eligible for Principal® Dental Access Plan?

You are. Once you pay for your membership - you're in. It's that easy. We've eliminated the bureaucracy, so you have no waiting periods, no annual maximums and your dental history is not a factor.

You have one of the largest credentialed networks at your service, so can feel confident

Principal® Dental Access Plan contracts with thousands of general dentists and specialists, so it's likely your dentist may already be participating in our network. If not, you can choose to nominate your dentist or find a new participating dentist near you. We've made every effort to make going to the dentist easy and affordable- the way it should be.

To learn more and request a list of participating dentists in your area, call us at 833-201-0142 or visit us online at www.principaldentalaccess.com

Immediate access to more than 300 procedures when you visit a participating general or specialist

Your Sample Savings[1]

PREVENTIVE CARE	Typical fee[2]	Avg plan fee[3]
Comprehensive Annual Exam	$114	$47
Full Mouth X-Rays	$186	$86
Two Adult Cleanings	$232	$122
TOTAL	**$532**	**$255**

Your savings = $277

COMMON PROCEDURES	Typical fee[2]	Avg plan fee[3]	Your savings[4]
White Filling (2 Surface-Front Tooth)	$242	$117	52%
Crown (Porcelain/Noble Metal)	$1,336	$722	46%
Periodontal Scaling & Root Planing (4+/Quad)	$317	$162	49%
Root Canal (Front Tooth)	$936	$483	48%
Extraction (Erupted Tooth)	$230	$95	59%
Dental Implant (Not Including Crown)	$2,671	$1,789	33%
OTHER PROCEDURES			
Full Orthodontic Case (Braces)	$6,500	$5,525	15%
Professional Teeth Whitening (Per Arch)	$439	$249	43%

(1) "Your sample savings" is based on an average nationwide fee schedule.

(2) "Typical fee" is the average 80th percentile of the 2024 FAIR Health fee schedule—a national profiling service.

(3) "Avg plan fee" is the average of the fixed fees nationwide—plan fees vary by dentist and region.

(4) "Your savings" is an average of the savings nationwide—savings vary by dentist and region.

This discount plan is not insurance.
Principal® Dental Access Plan provides discounts at certain healthcare providers for dental services. The plan does not make payments to the provider. Members must pay for all dental services but will get a discount from contracted providers. The range of discounts varies based on type of provider, region and services received. For a list of participating dentists, visit www.principaldentalaccess.com and choose "Find a dentist" under "For individuals and families." Dentists and specialists may not be available in all areas. Services in progress or provided before the membership effective date are excluded. Cancel within the first 30 days for a full refund, less the activation fee. Activation fees are refundable in AR and MD. This plan is not available in all states. Principal® Dental Access Plan is a product of Principal Financial Group®, the discount plan organization located at 9445 Farnham St, Ste. 100, San Diego, CA 92123. For more information, call 833-201-0142 or visit www.principaldentalaccess.com.

Principal Life Insurance Company®, a member of the Principal Financial Group®, Des Moines, IA 50392.

Opportunities to Enroll in Additional Life Insurance Attachment B

BENEFITS STORE INSURANCE SERVICES

- You have **$10,000** of Life Insurance coverage through your membership, however that is barely enough to cover basic funeral expenses. You need to consider how much insurance your family will need to pay off your remaining debts and survive comfortably without your income
- Now is your opportunity to elect an additional $50,000 of Life Insurance with no medical questions. **Enroll Now**
- You can also enroll your Spouse for $25,000 of Life Insurance and each Child for $10,000 of Life Insurance, no medical questions required. **Enroll Now**
- *** IMPORTANT *** This is a one-time offering. If you wish to elect any life insurance coverage for you or your family going forward, you will need to complete medical forms and may not be approved for the full amount you can enroll in today.

Life Insurance premiums have been substantially discounted since you're part of CREBP. The premiums are shown on the next page.

EXAMPLE: Sara wants to enroll in $50,000 of Life Insurance for herself

At a rate of .07 per $1,000, her monthly premium would be (.07 x 50,000) / 1000 = **$3.50**

MUTUAL of OMAHA

Enroll Now

LIFE INSURANCE

Opportunities to Enroll in Additional AD&D Insurance Attachment C

BENEFITS STORE INSURANCE SERVICES

- You have **$50,000** of AD&D Insurance coverage through your membership, so similarly to Life Insurance you have the opportunity during this enrollment period to purchase more
- Now is your opportunity to elect an additional **$500,000** of AD&D Insurance coverage without answering a single medical question. **Enroll Now**
- You can also enroll your Spouse for **$250,000** of AD&D Insurance and each Child for **$10,000** of AD&D Insurance, no medical questions required. **Enroll Now**
- *** IMPORTANT *** This is a one-time offering. If you wish to elect any life insurance coverage for you or your family going forward, you will need to complete medical forms and may not be approved for the full amount you can enroll in today.

AD&D premiums have been substantially discounted since you're part of CREBP. No matter your age, the rate is .03 per $1,000 of benefit.

EXAMPLE: Sally wants to purchase $500,000 of AD&D coverage for herself and $250,000 for her spouse

If the Total Coverage = $750,000, then monthly premium would be (.03 x 750,000) / 1000 = **$22.50**

Enroll Now

MUTUAL of OMAHA

LIFE INSURANCE

Vision Plan of America

Summary of Benefits for:

California Real Estate Benefit

(Group #571)

One of our strengths is the ability to customize a vision plan to meet the needs of our clients. This schedule of benefits is a standard example of a *Co Payment Vision Plan*. This plan offers UNLIMITED BENEFITS.

Plan M-PLUS

Benefits	Co-Payments
EXAM / REFRACTION	**$36**
LENSES	
Single Vision	**$42**
Bifocal	**$55**
Trifocal	**$79**
Progressive	**$139**
Tint #1	**No Charge**
FRAME	**25% Discount off UCR**

- **Please see the attached schedule for a complete list of co-payments.**

Vision Plan of America is now providing members ACCESS TO a Laser Vision Correction preferred pricing plan! The Qualsight Preferred Pricing Program offers an enhancement to your VPA plan including:

- **Savings** – you can now save 40-55% off the overall national average charge for LASIK!
- **Experienced Physicians** – national access to credentialed, Board Certified Ophthalmologists who use state-of-the-art, FDA approved LASIK equipment
- **Convenience** – our Care Managers provide a thorough prescreening process along with education about LASIK technologies, cost and benefits
- **Financing** – flexible financing available to qualified candidates.

To Access Preferred Pricing Call: 877 507 4448

Hours: 7 am - 9 pm (CST) Weekdays; 10 - 5 pm Saturdays

www.qualsight.com/-VPA

The Qualsight program is not an insured benefit. Vision Plan of America makes access to the Qualsight Program available to its members for preferred pricing FOR LASIK surgery. Vision Plan of America makes no specific recommendation for or against the Plan. All representations are those of Qualsight

Benefits and Copayments

Pair and a Spare Plan
Plan M+ & MO2

Description of Benefits and Copayments

MEMBER SERVICES	MEMBER PAYS
COMPLETE EYE EXAMINATION	**$36.00**
Including: Visual Acuity Test, Ophthalmoscopy (interior eye exam) Auto refraction where available Glaucoma Test, Cataract Screening And refraction (See note #1)	
LENSES (CR-39) (See note #2&3)	
Single Vision Lenses	$42.00
Bifocal Lenses (Rnd. 22 – FT 25-28)	$55.00
Trifocal Lenses (FT 7x25)	$79.00
Progressive (Generic)(i.e.-sola, v.i.p.,image)	$139.00
Progressive (Premium)	20% off UCR
Lenticular Lenses (S/V)	$180.00
Lenticular Lenses (B/F)	$240.00
LENS EXTRAS: (Add to lens cost)	
Oversized (over 58mm E.D.)	$15.00
Fashion Tints (each color, CR-9)	
Tint #1 (solid tint) plastic	**NO CHARGE**
Single gradient	$15.00
Double Gradient	$25.00
Photoxtra (S/V)	20% off UCR
Photoxtra (B/F)	20% off UCR
Photoxtra (Progressive)	20% off UCR
Photochromatic (i.e. transitions, sun sensor, etc.)	20% off UCR
Scratchcote (Plastic lenses)	$20.00
Polycarbonate	$45.00
Thin Lenses(other than polycarbonate)	20% off UCR
UV Coating	$10.00
Rimless (Edge Groove or Drill Mount)	20% off UCR
Prism (per D, per lens	$8.00
Frames	25% off UCR

MEMBER SERVICES	MEMBER PAYS
CONTACT LENSES (See note #4)	
Contact lens Evaluation & Fitting (Secondary examination)	25% off UCR
Hard Lenses (PMMA)	10% off UCR
R.P.G.	20% off UCR
Colors for cosmetic eye color changes	20% off UCR
Custom Contact Lenses (See note #5)	15% off UCR
(Orthokeratology, CTR)	**Not Covered**
Conventional Contact Lenses	15% off UCR
Multifocal	20% off UCR
***Except where prohibited by manufacturer**	

10% off 12 month supply or 5% off 6 month supply
10% off 12 month supply or 5% off 6 month supply of Standard and Multifocal soft Contact Lenses. (Except where prohibited by manufacturer)

ALL LENS PRICES ARE PER PAIR

ANY PROCEDURE OR LENS NOT LISTED AND PROVIDED BY THE SELECTED OPTOMETRIST IS AVAILABLE ON A FEE-FOR-SERVICE BASIS.

ADDITIONAL SERVICES	
Frame Repair (nose piece, screw replacement)	**NO CHARGE**
frame Adjustment	**NO CHARGE**

NOTE #1:
Refraction determines the need for prescription. The $36.00 co-payment must be paid directly to the doctor at the time of service. These benefits are part of and used in conjunction with your HMO package.

NOTE #2: (eye glasses or contact lenses)
Cost of lenses may have and additional charge when power of lenses exceeds ±6.00 D SPH or a when combined with ±2.00 D CYL.

VISION PLAN Of AMERICA

NOTE #3:
Any Multifocal add of ±3.25 or more may be charged an added laboratory fee per pair. SEGS larger than 28mm may be charged an added laboratory fee per pair. Glass lenses may have an additional charge.

NOTE #4:
When purchasing contact lenses you may require a contact lens evaluation in addition to a refraction.

NOTE #5:
Contact lens powers over ±6.25 D SPH and/or ±2.0 D CYL (combined) are considered custom, and will be charged extra. Medically necessary contact lenses may be considered custom; however, require prior authorization.

California Employee Enrollment Application For Small Groups Medical, Dental, and Vision

Anthem

Health care plans offered by Anthem Blue Cross and Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Submit application to your employer.

Please complete in black ink only.

Group/Case no. (if known)

Section A: Application Type — select one.

☐ New enrollment ☐ Open enrollment ☐ Qualifying event
☐ COBRA/Cal-COBRA ☐ Rehire date (MM/DD/YYYY) / /

If you select **Qualifying event or COBRA/Cal-COBRA**, please select one event reason.
☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Divorce or legal separation ☐ Death
☐ COBRA ☐ Cal-COBRA — Cal-COBRA applicants must submit first month's premium.
☐ Involuntary loss of coverage — please explain (required): _____
☐ Other — please explain (required): _____

Qualifying event or COBRA/Cal-COBRA date — Required (MM/DD/YYYY): / /

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required)

Home address – (P.O. Box not acceptable unless rural address)	City	State	ZIP code

County	Marital status	Employment status	Primary phone no
	☐ Single ☐ Married ☐ Domestic Partner (DP)	☐ Full-time ☐ Part-time	

Employer name
CREBP-NORBAR

Employee's physical work address (required)	City	State	ZIP code
PO BOX 238	ALAMO	CA	94507

Date of hire[2] (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins[2] (MM/DD/YYYY)	No. of hours worked per week
/ /	/ /	/ /	40

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Tagalog
☐ Other – please specify: _____

Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Employee email address: _____

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 If your employer imposes an orientation period for new hires, the "date of hire" is the first day after completion of the orientation period.

Section C: Type of Coverage — Your employer will advise you of your plan options and contract codes.

1. Medical Coverage	
Please Note: All health plans[2] include the required coverage for the dental and vision pediatric essential health benefits.	
Medical plan name[3]:	Contract code, if known:
Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family	
2. Dental Coverage — Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.	
Standalone dental plans do not include Essential Health Benefits.	
Dental plan name:	Contract code, if known:
Member dental coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family	
3. Vision Coverage	
These optional vision plans do not include coverage for vision pediatric essential health benefits.	
Vision plan name:	Contract code, if known:
Member vision coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family	

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 These plans are offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.
3 Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network, or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan you may be assigned to or be required to choose a different provider, network, and/or plan.

Social Security no.[1] _____

Section D: Family Information —

Complete this section for yourself and all dependents. All fields required. Attach a separate sheet if necessary.

Please access *Find Care* at anthem.com/ca to determine if your physician is a participating provider. For HMO plans: provide 3- or 6- digit Primary Care Physician no.

Dependent information must be completed for all additional dependents (if any) **to be covered under this coverage**. An eligible dependent may be your spouse or domestic partner, your children, children for whom you've assumed a parent-child relationship[2] (not including foster children) or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26). In the case of your child, the age limit of 26 does not apply when the child is and continues to be (1) incapable of self-sustaining employment by reason of a physically or mentally incapacitating injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance. The employee will be required to submit certification by a physician of the child's condition. List all dependents beginning with the eldest.

Employee Last name	First name	M.I.

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /

Primary Care Physician (PCP) name (if selecting an HMO[3] plan)	PCP ID no.	Existing patient ☐ Yes ☐ No

Primary Care Dentist (PCD) name (If selecting Dental Net DHMO plan)	PCD ID no	Existing patient ☐ Yes ☐ No

Spouse/Domestic Partner Last name	First name	M.I.	Social Security no.[1] (required) - -

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP name (if selecting an HMO[3] plan)	PCP ID no.	Existing patient ☐ Yes ☐ No

PCD name (If selecting Dental Net DHMO plan)	PCD ID no.	Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required) - -

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? _____

PCP name (if selecting an HMO[3] plan)	PCP ID no.	Existing patient ☐ Yes ☐ No

PCD name (If selecting Dental Net DHMO plan)	PCD ID no.	Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required) - -

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? _____

PCP name (if selecting an HMO[3] plan)	PCP ID no	Existing patient ☐ Yes ☐ No

PCD name (If selecting Dental Net DHMO plan)	PCD ID no.	Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 As defined in 2 CCR § 599.500(o).
3 Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network, or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan you may be assigned to or be required to choose a different provider, network, and/or plan.
4 Eligibility subject to Evidence of Coverage

Social Security no.[1] _____

Section E: Prior and Other Group Coverage

1. Is anyone applying for coverage currently enrolled in Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /
Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY) / /

2. Does anyone on this application intend to continue other coverage if this application is accepted? ☐ Yes ☐ No
3. Is anyone applying for coverage covered by other health, dental, or orthodontia coverage? ☐ Yes ☐ No
4. On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of Person covered (Last name, First, M.I.)	Type (select one)	Coverage (select all that apply)	Carrier name.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start / / End / /
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start / / End / /
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start / / End / /
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start / / End / /

Section F: Waiver/Declining Coverage — Proof of coverage will be required.

Type of coverage/Declined for: Select all that apply.		**Reason for declining/refusing coverage:** Select all that apply.
☐ Employee	☐ Medical ☐ Dental ☐ Vision	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by their employer's group coverage ☐ Enrolled in individual coverage ☐ Medicare/Medicaid/VA ☐ Enrolled in other Insurance — Please provide company name and plan: _____ ☐ Other — please explain: _____
☐ Spouse/ Domestic Partner	☐ Medical ☐ Dental ☐ Vision	
☐ Dependents	☐ Medical ☐ Dental ☐ Vision List name of dependents to be waived: _____	

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one, including but not limited to my employer, or agent, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, OR VISION COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, OR VISION COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL VISION, PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT. Please note Spouse/ Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined.

Special Open Enrollment

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the California Department of Managed Health Care that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event

Sign here only if you are declining coverage. DO NOT SIGN HERE IF YOU ARE APPLYING FOR COVERAGE

Signature of Applicant	Printed name	Date (MM/DD/YYYY)
X		/ /

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

Social Security no.[1] _____

Section G: Electronic Delivery of Materials.

Employee email address: _____

For **Medical** and all **Dental Net DHMO** plans offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.

I am providing my email address because I, and my enrolled dependents, want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage or Evidence of Coverage, grievance, appeals, and medical necessity determination notifications, Explanation of Benefits, other required notices and personalized information to help get the most out of the benefits. I understand I need to register on anthem.com/ca or the Sydney Health mobile app to get the most out of my plan's digital tools and I will make sure Anthem has my most up-to-date email address. I and my enrolled dependents understand that we can update our email addresses, change our communication preferences, and request a free copy of any materials at any time by going to anthem.com/ca or calling the Member Services number on my ID card.

For **Dental PPO** and **Vision** plans offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance. Anthem will deliver plan materials and related items by mail.

☐ By signing below, I and my enrolled dependents want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage, Evidence of Coverage, appeals, and medical necessity determination notifications, Explanation of Benefits, other legally required notices, and personalized information to help get the most out of the benefits. I understand I need to register on anthem.com/ca or the Sydney Health mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up-to-date email address. I understand that this consent is voluntary and that I and my enrolled dependents can opt out of electronic delivery at any time. We can update our email addresses, change our communication preferences, and request a free copy of any materials at any time by going to anthem.com/ca or calling the Member Services number on my ID card.

Applicant signature _____ Date_____

Section H: Terms, Conditions and Authorizations — Please read this section carefully before signing the application.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. To the best of my knowledge or belief, all statements and answers I have given are true and complete. I understand it is a crime to make or cause to be made a knowingly false or fraudulent material statement or material representation to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any acts of fraud or intentional misrepresentation of material fact in the application may result in loss of coverage within 24 months following the issuance of the coverage.

I certify each Social Security number listed on this application is correct.

I understand that I may not assign any payment under my Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company program. I agree to have money taken from my wages, if necessary, to cover the premium cost for the coverage applied for.

I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application or sold case coverage documents.

I understand that, to the extent allowed by law, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company reserves the right to accept or decline this application for coverage (and that Anthem Blue Cross Life and Health Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

I understand that coverages will become effective on the date established by the provisions of the group policy, contract and certificates issued thereunder.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and myself.

By providing a phone number, I agree and consent that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.

For Health Savings Account enrollees: I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem Blue Cross with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross with information regarding my HSA and that I may provide Anthem Blue Cross with a written request to revoke my authorization at any time.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Social Security no.[1] _____

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Read carefully — Signature required

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. For claims that exceed the jurisdiction of the small claims court that are subject to binding arbitration under this Agreement, California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. If your plan/policy is subject to 45 CFR 147.136, this agreement does not limit your rights to internal and external review of adverse benefit determinations as required by that law. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law.
By signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

Sign here	Applicant signature X	Date (MM/DD/YYYY) / /

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

Get help in your language

Language Assistance Services
Curious to know what all this says? We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。 您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

مهم: آیا می توانید این نامه را بخوانید؟ اگر نمی‌توانید، ما می‌توانیم از شخصی بخواهیم در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به صورت کتبی و به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً فوراً با شماره 1-888-254-2721 (TTY/TDD: 711) تماس بگیرید.

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721（TTY/TDD:711）にご連絡ください。

Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721. (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

The Benefits Store, Inc.

Association Benefits CA License No. 0680704

Credit Card Authorization / Automated Clearing House (ACH) Electronic Funds Transfer (EFT) Authorization

Insured Information	Payment Selection
Name:	CCA [ ] EFT / ACH [ ]
Email:	

Credit Card Transaction

Credit Card Information: **Mastercard** [ ] **Visa** [ ] **Discover** [ ]

Card Number:	**Exp: (MM / YY):**
Name (as appears on the card):	**Authorization Code:**

Address:	**City:**	**State:**	**Zip:**

Monthly Recurring Charges: I authorize the Benefits Store to charge this credit card for the monthly premium on the 20th of each month.

Yes [ ] **No** [ ] **Initials:** _____

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

Automated Clearing House (ACH) / Electronic Funds Transfer (EFT) Transaction

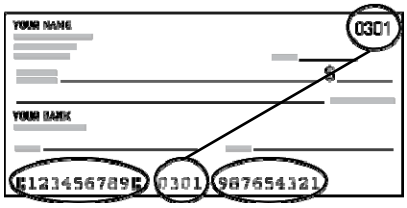
Name on Account:	**Name of Financial Institution:**
Routing Number (9 digits):	**Account Number:**

Account Holder Type: **Personal** [ ] **Business** [ ] **Account Type:** **Checking** [ ] **Savings** [ ]

Determining your routing number:

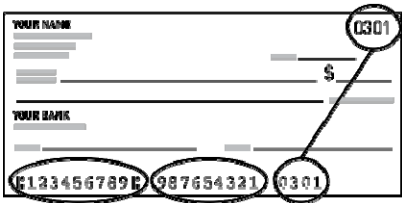
To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on you company check varies depending on your bank; for example:

Bank 1



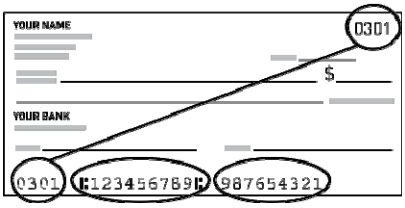
Routing # Check # Account #

Bank 2



Routing # Account # Check #

Bank 3



Check # Routing # Account #

I authorize the Benefits Store to deduct the monthly premium from this bank account.

Yes [ ] **No** [ ] **Initials:** **5th of the Month** [ ] **15th of the Month** [ ]

Monthly Recurring Charges (EFT)

Payment Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or debit the banking account listed above. I will not hold The Benefits Store, Inc. responsible for delay, loss or misapplication of funds due to incorrect or incomplete information supplied by me or my depository/credit institution.

Monthly Transactions Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or initiate debits (payments) to the financial institution indicated above. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to The Benefits Store, Inc. or upon the termination of the coverage through The Benefits Store, Inc. Should a rate change due to policy renewal, age band change or coverage tier occur, I authorize The Benefits Store, Inc. to automatically make the adjustment to my monthly deduction.

Note: I understand and authorize a $25 service charge may be applied against my account for all denied transactions for any reason.

Authorized Signature:	Date:
Payment Amount:	$ _____

The Benefits Store, Inc. - PO Box 238 Alamo, CA 94507 - Membership / Accounting : 800-446-2663 - Email: CustomerService@BenefitsStore.com

BENEFITS STORE, Inc.
Association Benefits

BENEFITS STORE, Inc.
Association Benefits

BENEFITS STORE, INC.
CA Insurance License #0680704

IMPORTANT NOTICE

NEW CUSTOMER SERVICE ACCESS FOR MEMBERSHIP ACCOUNTING AND BILLING QUESTIONS

PHONE NUMBER: (888) 226-8373 FAX: (925) 855-2051

EMAIL: CUSTOMERSERVICE@BENEFITSSTORE.COM

MAILING ADDRESS: BENEFITS STORE/ MEMBERSHIP ACCOUNTING

PO Box 238

Alamo, CA 94507

Electronic Funds Transfer (EFT)/Automated Clearing House (ACH)

You may do a one time transaction or monthly deduction.

RELIABLE!

EFT/ACH is a method of automatically withdrawing or depositing funds to an individual's bank account.

SAFE!

All EFT/ACH transactions are tracked and governed by the Federal Reserve. Only preauthorized transactions are allowed to be processed.

EFT MONTHLY PAYMENTS!

You will never again need to worry about late payments due to mail delays, misplaced payments or forgotten payments! Your payment will always be made on time.

SIMPLE!

Once you have completed and signed the EFT authorization form, all you need to do is record the payment transaction in your checkbook or savings register on the designated payment date.

Monthly Invoice / Check

Premiums are payable in advance of the month of coverage. You will receive your monthly Premium billing on or about the first of each month

Example: Premiums for July coverage are billed on June 1st and payable (received) on or before June 20th.

Late fees are charged for payments received after the 20th.

Your full payment must be received by the 20th to avoid a late charge. We suggest that you mail your payment on or before the 12th of each month

Payments **MUST** be mailed to:

The Benefits Store, Inc.
P.O. Box 743322
Los Angeles, CA 90074-3322

To assure proper credit make sure to include the top portion of the billing statement with your payment. Also enter the full Subscriber's name in the memo field of your check.

On-Line Bill Payment

Premiums are payable in advance of the month of coverage.

To use On-Line Bill Payment, you will need to arrange for your financial institution to generate a check in payment for your coverage.

As an example, the following links will connect you with major banks for establishing this service

www.Bankofamerica.com
B of A - Online Banking Info

www.Wellsfargo.com
Wells Fargo - Online Banking Information

Your full payment must be received by the 20th to avoid a late charge. We suggest that you initiate your on-line payment on or before the 10th of each month.

Payments **MUST** be mailed to:

The Benefits Store, Inc.
P.O. Box 743322
Los Angeles, CA 90074-3322

To assure proper credit make sure to instruct your bank to show the full Subscriber's name in the memo field of your check.

Credit Card Payment Visa or MasterCard

Premiums are payable in advance of the month of coverage.

We accept Visa, MasterCard for monthly premium payments,

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

The Credit Card Authorization form may be downloaded from the **Forms section** on our web site www.BenefitsStore.com

To do so, click on the "Forms" tab located in the bar crossing our home page or select the following link Credit Card Authorization Form

Your full payment must be received by the 20th to avoid a late charge. We suggest you initiate your credit card payment on or before the 17th of each month.

For processing, Credit Card Authorization forms must be faxed to (925) 855-2051

Contact us at (888) 226-8373 with any questions about completing this form.

Your Benefits Bill:
Frequently Asked Questions

The Benefits Store is committed to supporting you. Count on us to provide the products, expertise and support you need!

How do I receive my bill?

You have the option to receive a paper copy of your bill via mail, or a digital copy via email.

When will I receive my bill?

You will receive your bill on or by the first of the month.

When is my premium due?

Your premium will always be due by the 20th of each month prior to next month's coverage.

When will I see my adjustments or payments?

Any adjustments or payments made before your bill date will be reflected on your next invoice. All adjustments or payments made after your bill date will reflect on the following month's invoice.

(Example: if your bill date is on the 26th of the month, an adjustment/payment made on the 27th would reflect on the following month's invoice.)

How do I submit my payment?

There are multiple options for submitting payments.

Check

Checks must be mailed to:
The Benefits Store
PO Box 743322
Los Angeles, CA 90074-3322

Credit Card – ACH/EFT

- *if using a credit card, there is a 2.5% transaction fee added to each payment made*

If I'm on autopay, will I still receive a bill?

Yes, even if you are enrolled in automatic payments, an invoice will still be mailed to you.

My coverage was terminated for non-payment, can I get my coverage reinstated?

A reinstatement request requires the account to be paid through the most current billing cycle and is subject to review and approval from the carrier.