# Spectera-UHC VISION PLAN*

## ENROLLMENT INSTRUCTIONS

**Please Type or Print Clearly using only Black Ink, DO NOT USE Felt Tip Pens.**

***MEMBER / APPLICANT INFORMATION:***

**Member/Applicant:** _____

**Local REALTOR ® Assoc. Name:** _____

**E-Mail Address:** _____

**Requested effective date of coverage: 1st of _____, 20__**

**New Enrollee [ ]** **Current Benefits Store Member Changing Plans [ ]**

Remember to attach your business card and this form to your application
The applicant must be a member of a Local REALTOR® Association or a W2 Employee of a member firm.

***SELECTING YOUR PLAN:***

[ ] Spectera - Unitedhealthcare Vision

***COMPLETING THE APPLICATION:***

**USE BLACK INK AND COMPLETE ALL SECTIONS**

***EFFECTIVE DATE OF COVERAGE:***

**Applications are accepted (must be received in our office) be the 15th of the current month for coverage to be effective the 1st of the following month.**

**To avoid confusion about the effective date of coverage, make sure to clearly show the requested effective date of coverage you are applying for on the application, your premium check and this form.**

**Applications are batched by group to the insurers monthly. Any application received after the 15th of the current month will be part of the next month's application batch.**

***TO ENROLL:***

Review the application for accuracy, sign, date, and return to us with your premium. **Make Checks Payable to The Benefits Store Trust Account.**

***U.S. MAIL(1St Class or Priority)***
ATTN: ENROLLMENT
Benefits Store, Inc.
**PO Box 238, Alamo, CA 94507**

***PROCESSING REQUIREMENT:***

**NOTE: Incomplete applications or applications without the correct premium included cannot be processed.**

**One (1) months premium is required with your application.**



www.BenefitsStore.com
CA Insurance License No.: 0680704
Voice: (800) 446-2663 - Fax: (925) 855-2051

# Spectera-UHC VISION PLAN*

## ENROLLMENT INSTRUCTIONS

***PREMIUM PAYMENTS:***

***You have four (4) ways to pay your monthly premium:***

**Electronic Funds Transfer (EFT)**
**Monthly Invoice/Check**
**On-Line Bill Payment**
**Credit Card Payment/Visa, MasterCard, Discover or American Express**

**For your convenience we have included an EFT Authorization form with the Enrollment Form.**

***APPLICATION PROCESSING:***

Allow 7 business days after the 15th of the current month for the processing of your application and for you to appear in the Vision Plan's database. An Email Confirmation will be automatically generated to you with your group policy number and plan information. DON'T DELAY – ENROLL TODAY! To avoid this delay we urge you to submit your application to us as soon as possible.

**You should not cancel your current coverage until you are notified of your new coverage.**

**For verification of your new coverage, E-mail:**

**Enrollment@BenefitsStore.com**

*This program is a special benefit for members of local REALTOR® Associations within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your Association, Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.



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(DO NOT STAPLE)

**CALIFORNIA**

# Small Business Employee Enrollment Form

UnitedHealthcare®

## UnitedHealthcare Insurance Company
## UnitedHealthcare of California

**To speed the enrollment process, please be thorough and fill out all sections that apply.**

**To Be Completed by Employer**

Group Name/Number

**Requested Effective Date of Insurance / Health Plan Coverage / Date of Change** / /

**Date of Hire** / /

Position/Title

Hours Worked Per Week

Reason for Application
- ☐New Group Plan
- ☐New Hire
- ☐Dependent Add/Delete
- ☐Annual Open Enrollment
- ☐Change Name/Address
- ☐Late Enrollee
- ☐Termination Date: ____/____/____
- ☐Waiving Coverage (Complete Sections A and E)
- ☐Life Event/Date ____
- ☐Status Change ____
- ☐Other ____

Employee Type (check all that apply)
- ☐Active ☐Union ☐Non-Union ☐Retired
- ☐Hourly ☐Salary ☐Other ____
- ☐COBRA ☐Cal-COBRA
- Start Date ___/___/____ End Date___/___/____
- Indicate Qualifying Event ____
- Original Qualifying Event Date
- Start Date ___/___/____ End Date___/___/____

## A. Employee Information

**Complete All Sections**
**If you are waiving coverage, please complete only Sections A and E**

| Last Name | First Name | MI | Social Security Number | Home Phone/Cell / Work Phone |
|---|---|---|---|---|
| | | | | |

| Address | Apt # | City | State | ZIP Code | Email Address |
|---|---|---|---|---|---|
| | | | | | |

Date of Birth / /

Sex ☐M ☐F

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner

Preferred Language: ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other ____

Primary Care Physician[1] Name: ____
Address ____
ID# ____ Existing Patient Medical ☐Yes ☐No

Primary Care Dentist[2] Name: ____
ID#: ____
Existing Patient Dental ☐Yes ☐No

## B. Dependent Information

**List All Enrolling (attach sheet if necessary)**

Name (Last, First, M)
Social Security Number ___-___-____
Sex ☐M ☐F
Relationship[3] Spouse/Domestic Partner
Birth Date ___/___/____

Address (if different from Employee)

Preferred Language
☐English ☐Spanish ☐Chinese ☐Vietnamese
☐Korean ☐Other ____

Primary Care Physician[1] Name: ____
Address: ____
ID# ____ Existing Patient Medical ☐Yes ☐No

Primary Care Dentist[2] Name: ____
ID#: ____
Existing Patient Dental ☐Yes ☐No

Name (Last, First, M)
Social Security Number ___-___-____
Sex ☐M ☐F
Relationship[3] Dependent
Birth Date ___/___/____

Address (if different from Employee)

Please check box when selecting HMO health plan coverage:
Permanently disabled and age 26 or older[4] ☐Yes ☐No

Preferred Language
☐English ☐Spanish ☐Chinese ☐Vietnamese
☐Korean ☐Other ____

Primary Care Physician[1] Name: ____
Address: ____
ID# ____ Existing Patient Medical ☐Yes ☐No

Primary Care Dentist[2] Name: ____
ID#: ____
Existing Patient Dental ☐Yes ☐No

IMPORTANT: (1) Please use the UnitedHealthcare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (2) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (3) For court-ordered dependent, legal documentation must be attached. (4) Applicable to HMO health plan coverage selection: If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

**Subscriber Last, First Name** _____ **SSN** _____

## B. Dependent Information (continued)

| Name (Last, First, M) | Sex | Relationship[3] | Birth Date |
|---|---|---|---|
| Social Security Number ___-___-____ | ☐M ☐F | Dependent | ___/___/_____ |
| Address (if different from Employee) | | | Please check box when selecting HMO health plan coverage: Permanently disabled and age 26 or older[4] ☐Yes ☐No |
| | | | Preferred Language ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other _____ |
| Primary Care Physician[1] Name: _____ Address: _____ ID# _____ Existing Patient Medical ☐Yes ☐No | | | Primary Care Dentist[2] Name: _____ ID#: _____ Existing Patient Dental ☐Yes ☐No |

| Name (Last, First, M) | Sex | Relationship[3] | Birth Date |
|---|---|---|---|
| Social Security Number ___-___-____ | ☐M ☐F | Dependent | ___/___/_____ |
| Address (if different from Employee) 123456 123456 | | | Please check box when selecting HMO health plan coverage: Permanently disabled and age 26 or older[4] ☐Yes ☐No |
| | | | Preferred Language ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other _____ |
| Primary Care Physician[1] Name: _____ Address: _____ ID# _____ Existing Patient Medical ☐Yes ☐No | | | Primary Care Dentist[2] Name: _____ ID#: _____ Existing Patient Dental ☐Yes ☐No |

## C. Product Selection

**Check the box for each plan you or your dependents are enrolling in. Benefit offerings are dependent on employer selections.**

| Person | Medical | Dental | Vision | **Medical Plan and Dental Plan Selection –** Write in the Plan Code or Description of the Medical and Dental plan in which you wish to enroll. |
|---|---|---|---|---|
| Employee | ☐ | ☐ | ☐ | Medical Plan Code/Description: _____ |
| Spouse/Domestic Partner | ☐ | ☐ | ☐ | Dental Plan Code/Description: _____ |
| Dependents | ☐ | ☐ | ☐ | |

## D. Other Medical Insurance/Health Plan Coverage Information

**This section must be completed. (Attach sheet if necessary.)**

On the day this insurance/health plan coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other medical insurance/health plan coverage, including another UnitedHealthcare plan or Medicare?

☐YES (continue completing this section) ☐NO (If NO, then skip the rest of the Other Medical Insurance/Health Plan Coverage section.)

Name of other carrier _____

| Other Group Medical Insurance/Health Plan Coverage Information (only list those covered by other plan) | Type (B/S/F)[†] | Effective Date MM/DD/YY | End Date MM/DD/YY | Name and date of birth of policyholder/covered employee for other insurance/health plan coverage |
|---|---|---|---|---|
| Employee: | | / / | / / | |
| Spouse/Domestic Partner Name: | | / / | / / | |
| Dependent: | | / / | / / | |
| Dependent: | | / / | / / | |
| Dependent: | | / / | / / | |

[†]B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (married).
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Coverage provided by "UnitedHealthcare and Affiliates":
**Check appropriate box(s) for coverage(s) selected:**
Medical ☐ UnitedHealthcare Insurance Company (Insurance Products: Select, Select Plus, Non-Differential PPO)
Medical ☐ UnitedHealthcare of California (HMO)
Dental ☐ UnitedHealthcare Insurance Company or ☐ Dental Benefit Providers of California, Inc.
Vision ☐ UnitedHealthcare Insurance Company
Administrative services provided by United Healthcare Services, Inc., OptumRx, Inc. or OptumHealth Care Solutions, Inc. Behavioral health products by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Subscriber Last, First Name _____ SSN _____

## D. Other Medical Insurance/Health Plan Coverage Information (continued)

**If you and/or an enrolling dependent are enrolled in Medicare, complete this section (attach additional sheets if necessary):**

Medicare – Employee/Spouse/Domestic Partner/Dependent Name: _____

Medicare ID# _____ (Please attach a copy of your Medicare ID card.)

☐ Enrolled in Part A: Effective Date _____/_____/_____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____/_____/_____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____/_____/_____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
☐ Disabled ☐ Disabled but actively at work

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work
Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date_____/_____/_____

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

## E. Waiver of Coverage

**Complete only if you are waiving coverage for yourself and/or any family member.**

I decline coverage for:

| | Medical | Dental | Vision |
|---|---|---|---|
| Myself | ☐ | ☐ | ☐ |
| Spouse/Domestic Partner | ☐ | ☐ | ☐ |
| Dependent Children | ☐ | ☐ | ☐ |
| Myself and all dependents | ☐ | ☐ | ☐ |

Declining coverage reason:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ COBRA/Cal-COBRA/AB-1401 from Prior Employer
☐ California Health Benefit Exchange
☐ Covered by Medicare ☐ Medicaid ☐ I (we) have no other coverage at this time
☐ Tri-Care ☐ VA Eligibility ☐ Other _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have been given the right and have been given the chance to apply for coverage. I have decided not to enroll myself and/or my dependent(s), if any.

I now decline to enroll myself, my spouse/domestic partner and/or my dependent(s) in my employer health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THE GROUP MEDICAL PLAN. THE WAIT OF UP TO TWELVE (12) MONTHS WILL NOT APPLY IF I AND/OR MY DEPENDENTS ARE ENTITLED TO AN OFF-CYCLE ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT.)**

The wait of up to twelve (12) months will not apply if:

1. I certify at the time of initial enrollment that the coverage under another employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, and I lose coverage under that employer health benefit plan, Healthy Families Program, Access for Infants and Mothers (AIM) Program, Covered California, California's Health Benefit Exchange; or no share-of-cost Medi-Cal;
2. My employer offers multiple health benefit plans and I elected a different plan during an open enrollment period;
3. A court orders that I provide coverage under this plan for a spouse or child;
4. I have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption and if enrollment is requested within 30 days after the marriage, domestic partnership, birth, adoption or placement for adoption;
5. I or my eligible dependents lose health care coverage due to a qualifying event such as loss of employment for any reason other than gross misconduct, reduction of employment hours, death or entitlement to Medicare.

If I am declining enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Please examine your options carefully before declining this coverage.

| Employee Signature (only if waiving coverage for self and/or dependents) | Date _____/_____/_____ |
|---|---|

Subscriber Last, First Name _____ SSN _____

## F. Application Signature

I understand that I am completing a health application and, to the best of my knowledge, that each response is complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. Please maintain a copy of this authorization for your records.

Please note that if UnitedHealthcare can demonstrate you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare may rescind your coverage. UnitedHealthcare will issue a written notice via regular certified mail at least 30 days prior to the effective date of the rescission explaining the basis for the decision of rescission and your appeal rights. No agreement /policy will be rescinded after 24 months following the issuance of the agreement/policy. In addition, in the event it is found you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare may cancel your coverage, as permitted by law.

| Employee Signature (if applying for coverage) | Employee Name (please print) | Date<br>_____/_____/_____ |
|---|---|---|

## G. Binding Arbitration Applicable to UnitedHealthcare of California (HMO) Enrollees Only

**I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEATHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION IN ACCORDANCE WITH CALIFORNIA ARBITRATION LAW (TITLE 9 OF THE CALIFORNIA CODE OF CIVIL PROCEDURE § 1280 ET SEQ.) EXCEPT WHERE SUCH LAWS MAY BE PREEMPTED BY FEDERAL LAW INCLUDING, BUT NOT LIMITED TO, THE FEDERAL ARBITRATION ACT, 9 U.S.C. SEC. 1, ET SEQ.**

| Employee Signature (required) | Employee Name (please print) (required) | Date (required)<br>_____/_____/_____ |
|---|---|---|

## H. Census Information

NOTE: Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino
☐ American Indian/Alaska Native ☐ Asian ☐ Other Race, please specify _____

**CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.**

# 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:** Visa [ ] Mastercard [ ] Discover [ ] American Express [ ]

**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

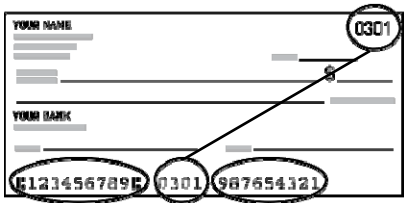
**Name on Account:** **Name of Financial Institution:**

**Routing Number (9 digits):** ___-___-___-___-___-___-___-___-___ **Account Number:** ___-___-___-___-___-___-___-___-___-___-___-___-___-___-___

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

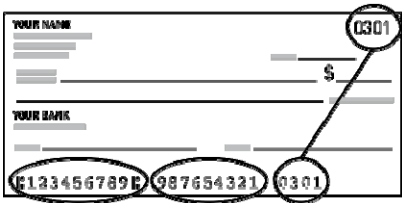
***Determining your routing number:***
**To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on you company check varies depending on your bank; for example:**

**Bank 1**



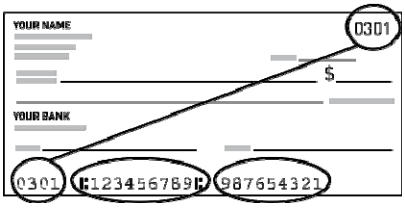

**Routing # Check # Account #**

**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: BILLING@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.