CREBP Benefit Package with Kaiser, Mutual of Omaha New Dental Choice, and Vision Plan of America

Member/Applicant: _____

Local REALTOR® Association Name: _____

Member Email Address: _____

Requested Effective Date of Coverage: _____

Plan Name: _____

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

Instructions: Complete the section for the plan above.

Before selecting a plan, refer to the EOC (Explanation of Coverage) or SBC and consult with an agent.

CREBP Benefit Package Kaiser Plan Options

CREBP Benefit Package Kaiser Plan Options:

"MOST AFFORDABLE" PLANS

[ ] $0/$2,000 Deductible Plan HSA
[ ] $0/$3,000 Deductible Plan HSA
[ ] $30/$3,000 Deductible Plan HSA
[ ] $30/$1,500 Deductible Plan HRA
[ ] $30/$2,500 Deductible Plan HRA
[ ] Bronze 5400/60 – ACA Plan
[ ] Bronze 6300/65 – ACA Plan
[ ] Bronze HSA 7000/0 – ACA Plan

"BEST BENEFITS" PLANS

[ ] $5 Copayment Plan
[ ] $15 Copayment Plan
[ ] $20 Copayment Plan
[ ] $30 Copayment Plan
[ ] Platinum 0/10 – ACA Plan
[ ] Platinum 0/20 – ACA Plan
[ ] Gold 0/30 – ACA Plan
[ ] Gold 250/35 – ACA Plan
[ ] Gold 1000/40 – ACA Plan
[ ] Gold HRA 2250/35 – ACA Plan
[ ] Gold HSA 1650/15% – ACA Plan

"BEST BALANCE/VALUE" PLANS

[ ] $50 Copayment Plan
[ ] $30/$1,000 Deductible Plan
[ ] $30/$1,500 Deductible Plan
[ ] $40/$2000 Deductible Plan
[ ] Silver 1900/65 – ACA Plan
[ ] Silver 2300/65 – ACA Plan
[ ] Silver 2700/25% HSA – ACA Plan
[ ] Silver 2500/55 – ACA Plan
[ ] Silver 2800/65 – ACA Plan

ELIGIBILITY REQUIREMENT - In all cases, membership in a Local Realtor Association must be in effect to enroll, the membership must be maintained 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 Plan of America. 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 Kaiser Member ID until you receive your official member ID card.
- Kaiser Data Base - allow 12 business days from our receipt and processing of your enrollment
- Kaiser 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 CREBP 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.

KAISER PERMANENTE®

newdentalchoice you save you smile

Mutual of Omaha

VISION PLAN OF AMERICA

Enhanced Benefits Included

Special Discount Dental Plan

- The New Dental Choice 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.
- New Dental Choice 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. **Please see the attached schedule for a complete list of co-payments.**
- ***You have additional opportunities to upgrade your Vision Benefit Plan.***

newdentalchoice
you save you smile

Included In Your Plan Now

New Dental Choice is a product created by practicing dentists who see on a daily basis how the current dental care system could be improved. Their collaboration resulted in New Dental Choice, a dental savings plan designed for individuals, families and groups of all sizes.

You have the power to decide with New Dental Choice when to visit a qualified dentist and how often. There are no limitations on visits and how much money you can save. Your membership fee entitles you to savings on everything from routine checkups to major treatments. And because New Dental Choice is not insurance, you're not paying monthly premiums for services you may or may not use.

A dental plan with no surprises

Just present your New Dental Choice Membership card to any participating dentist and receive fixed, discounted fees on all dental care including cosmetic procedures and dental implants. We've eliminated the hassles. There are no waiting periods, no annual maximums, no hidden fees, and your dental history is never a factor.

Feel confident. You have one of the largest credentialed networks at your service

New Dental Choice contracts with thousands of general dentists and specialists, so it's likely your current 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.

For a complete list of fees or to find a participating dentist in your area: Call us at (888) 632-3676 or visit www.newdentalchoice.com

More than 300 procedures are discounted to fixed fees at partcipating general dentists and specialists

your sample savings[1]

Procedures	Typical Price [2]	Avg Plan Fee [3]	Your Savings [4]
Oral Exams	$114	$45	61%
Cleaning	$113	$76	33%
X-Rays	$179	$82	54%
Cavity Filling	$183	$103	44%
Crown	$1,247	$838	33%
Extraction	$628	$432	31%
Root Canal	$848	$530	38%
Implant	$3,024	$1,722	43%

[1] *"Your Sample Savings" is based on dentist average fees in California*

[2] *"Typical price" is the average 80th percentile of the 2013 Fairhealth fee schedule - a national profiling service*

[3] *"Avg Plan Fee" is the average of the fixed fees for dentists in California - fees vary by provider*

[4] *"Your Savings" is an average for dentists in California - fees vary by area*

www.newdentalchoice.com

Opportunities to Enroll in Additional Life Insurance

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

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.

KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

Use this form to enroll in Kaiser Permanente. (All fields with * are required.)

COMPANY & PLAN INFORMATION

Company name*	Group ID (if assigned)	Effective date* (can only start the first of the month)
California Real Estate Benefit Plan (CREBPT)		/ 01 /

Plan selection*	**Subgroup ID** (if assigned)	Employee classification (if applicable)

Enrollment reason (Please check one) ☐ New group account ☐ Open enrollment ☐ Other:

If you have an **existing** account, please email completed form to **csc-sd-sba@kp.org** as a PDF attachment or fax to **855-355-5334.**

EMPLOYEE INFORMATION

Have you ever been a member of, or received care from, Kaiser Permanente in California? ☐ Yes ☐ No

Social Security number*	Former/Maiden name		
Last name*	First name*	MI	Preferred language (optional)

Home address*	Apt. #

City*	State*	ZIP*	County

Mailing address (if different from home)	Apt. #

City	State	ZIP	County

Date of birth (mm/dd/yyyy)*	Gender*	Day phone	Evening phone
/ /	☐ M ☐ F ☐ Undeclared	( ) –	( ) –

If you decline coverage for yourself or an eligible dependent, you can only enroll during an annual open enrollment period established by your employer, or during a special enrollment period if you've experienced a qualifying event. You must request coverage within 60 days of a qualifying event. Special enrollment qualifying events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court order that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that's serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that's been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual didn't enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

*(All fields with * are required.)*

KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

FAMILY INFORMATION (Please list only those family members to be enrolled.)

Check one ☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)*			
Former name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			

If any dependent listed above lives at another address, complete the following:

Name (Last, First, MI)	Address
Name (Last, First, MI)	Address

READ AND SIGN

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT†

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that can't be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Employee name (please print)*

Employee signature* X	Date

(All fields with * are required.)

†Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage aren't subject to binding arbitration: 1) Preferred Provider Organization (PPO) plans and 2) KPIC Dental plans.

Email completed form to **csc-sd-sba@kp.org** or fax to **855-355-5334.**

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

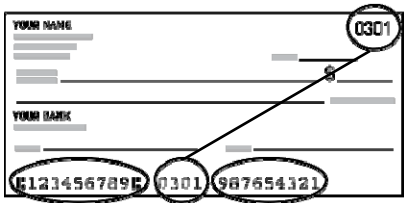
Name on Account:	**Name of Financial Institution:**
Routing Number (9 digits):	**Account Number:**

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

Determining your routing number:

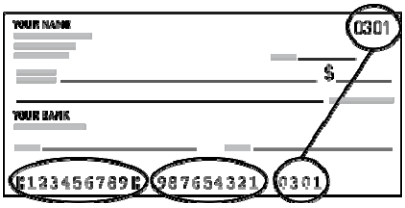
To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on you company check varies depending on your bank; for example:

Bank 1



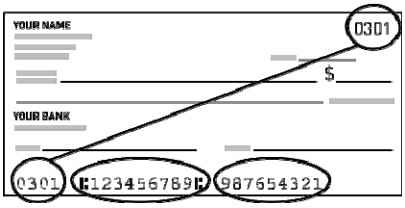
Routing # Check # Account #

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.