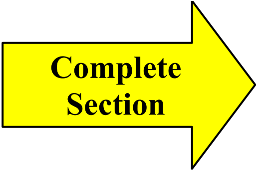
MEMBER / APPLICANT INFORMATION:



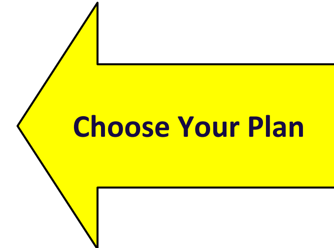
Member/Applicant: ______________________________
Local REALTOR ® Assoc. Name:______________________________
Member E-Mail Address:______________________________
Requested effective date of coverage: 1st of ______________________ , 20 __

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

The applicant must be a member/affiliate member of a Local REALTOR® Association.
W2 Employees of a member firm – Please call our office at 1-800-446-2663

SELECT YOUR PLAN

PLEASE CHOOSE ONE PLAN ONLY



"MOST AFFORDABLE" PLANS

[ ] $0/$2,000 Deductible Plan with HSA Option
[ ] $0/$2,700 Deductible Plan with HSA Option
[ ] $30/$3,000 Deductible Plan with HSA Option
[ ] $30/$1,500 Deductible Plan with HRA Option
[ ] $30/$2,500 Deductible Plan with HRA Option
[ ] Bronze 5000/60
[ ] Bronze HSA 3500/30
[ ] Bronze HSA 4500/40%

"BEST BALANCE/VALUE" PLANS

[ ] $50 Copayment Plan
[ ] $30/$1,000 Deductible Plan
[ ] $30/$1,500 Deductible Plan
[ ] $40/$2,000 Deductible Plan
[ ] $40/$3,000 Deductible Plan
[ ] Silver 1000/40
[ ] Silver 1500/45
[ ] Silver Ho˚ /1500/20%
[ ] Gold 0/30
[ ] Gold 500/30
[ ] Gold HRA 2000/30

"BEST BENEFITS" PLANS

[ ] $5 Copayment Plan
[ ] $15 Copayment Plan
[ ] $20 Copayment Plan
[ ] $30 Copayment Plan
[ ] Platinum 0/20

Signatures are required on the Kaiser Enrollment Form and on the Kaiser Enrollment Review and Information Page (the last page of the Enrollment package) to complete the Enrollment Process.

Special Benefits

Your Kaiser Plan through the Benefits Store, Inc. includes a Discount Dental Plan and a $10,000 Life Insurance Policy with an Accidental Death and Dismemberment benefit.

APPLICATION INSTRUCTIONS

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

SECTION A **DO NOT Complete** -*Company Name, Group Account Number, Enrollment Unit, Plan Description, Employee Classification, Date of Hire or Enrollment Reason* – **The Benefits Store will complete this information.**

SECTION B **Complete** all of the Personal Information questions.

SECTION C **Complete** – ***Family Information***. The subscriber must complete all fields for any dependents being enrolled. Social Security numbers are required for coverage for all dependents.

SECTION D **Sign and Date** - *Signature Required for Terms and Conditions and Arbitration Disclosure –* ***Read Carefully:*** Applications CAN NOT be processed without a signature and date

CA Insurance License No.: 0680704
Enrollment / Billing Department: (888) 226-8373 Fax: (925) 855-2051

Kaiser Permanente
Enrollment Review & Information

The Benefits Store
California Local Realtor Association Benefits

EFFECTIVE DATE OF COVERAGE:

Applications are accepted (must be received in our office) through the end 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.

TO EN ROLL:

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)	***OVERNIGHT/EXPRESS DELIVERY ONLY***
ATTN: ENROLLMENT - KAISER	ATTN: ENROLLMENT - KAISER
Benefits Store, Inc.	Benefits Store, Inc.
PO Box 238, Alamo, CA 94507	**85 High Eagle Road, Alamo, CA 94507-2009**

PROCESSING REQUIREMENT:

NOTE: INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT THE CORRECT PREMIUM INCLUDED CANNOT BE PROCESSED.

Applications Postmarked by the 15th

One (1) months premium is required with your application if enrolling for coverage beginning the 1st of the following month and postmarked by the 15th

Applications Postmarked after the 15th

Two (2) months premium is required with your application if enrolling for coverage beginning the 1st of the following month and postmarked after the 15th. Note – the two (2) month premium requirement is waived with the use of the EFT/CCA monthly payment option.

APPLICATION PROCESSING:

Allow 12 business days for the processing of your application and for you to appear in Kaiser's database. Kaiser ID Card(s) are normally generated within 15 working days from the time we receive your application. If we do not receive your application until the 20th of the month you may not receive your ID card(s) until the 15th of the following month. To avoid this delay we urge you to submit your application to us as soon as possible.

THOSE APPLYING WITH CURRENT COVERAGE:

Remember, everyone applying during the Open Enrollment or through a qualifying event will be accepted! Coverage is guaranteed! Those of you that have paid your current coverage premiums in advance need to request an effective date for your new coverage that will match the date when your current coverage ends. Those of you that are within the "grace period" for premium payment of your current coverage need to verify with your current insurer the length of time allowed for your coverage before cancellation.

You should not cancel your current coverage until you are notified of your new coverage. For verification of your new coverage, please contact The Benefits Store.

ADDITIONAL INFORMATION – Premiums are based on actual age and are billed monthly.

To cancel your coverage or to revoke your application, we require a written notice of your intent including your signature and your requested date of cancellation. We ask this statement be written on a copy of your billing statement and faxed to The Benefits Store at **925-855-2051** or mailed to our Membership Accounting department. Please visit our website for additional contact information. This notice must be received no later than 12 noon (M-F) BEFORE the 20th of the month in which you wish to cancel. For example, April 20th for an effective cancellation date of April 1st.

By signing your enrollment application you represent that all of the information you have included is complete and accurate, and that you accept all terms of this application and supporting documentation.

Acknowledgement Signature: ______________________________ **Date:** ______________

*This program is a special benefit for members/affiliate 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.

www.BenefitsStore.com
CA Insurance License No.: 0680704
Enrollment / Billing Department: (888) 226-8373 Fax: (925) 855-2051

ENROLLMENT FORM

Please use black ink. See instructions on page 3 before completing this form. Make a copy for your records.

A To be completed by EMPLOYER

☐ New group account ☒ Existing group account

California Real Estate Benefit Plan
Company name ________ Group number ________ Date coverage to be effective ___/___/___

Enrollment unit ________ Plan selection ________ Employee classification *(if applicable)* ________

Employee name ________ Date of hire ___/___/___

Enrollment reason *(Please check one.)*

☐ New group account ☐ New hire ☐ Open enrollment ☐ Part-time to full-time ___/___/___

☐ Loss of coverage ___/___/___ ☐ Other ________ Event date ___/___/___

B To be completed by EMPLOYEE

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

If so, under what medical record number *(if known)*? ________ Former/Maiden name? ________

Name (Last, First, MI) ________ Social Security number ________ Preferred spoken or written language *(optional)* ________

Home address ________ Apt no. ____ City ________ State ____ ZIP code ________

Date of birth ___/___/___ Gender ☐ M ☐ F Home phone ________ Work phone ________

C Family information

☐ Spouse ☐ Domestic partner	Date of birth	Gender ☐ M ☐ F	Social Security no. ________
Name (Last, First, MI) ________			Medical record no. *(if known)* ________
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no. ________
Name (Last, First, MI) ________			Medical record no. *(if known)* ________
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no. ________
Name (Last, First, MI) ________			Medical record no. *(if known)* ________
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no. ________
Name (Last, First, MI) ________			Medical record no. *(if known)* ________

Will you be adding additional dependents? ☐ Yes ☐ No Add any additional dependents on page 2.

D Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement* :

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), 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 or coverage by KPIC, 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* and in the *Certificate of Insurance*.

X ____

Signature required for all Kaiser Permanente plans Date
(Excluding KPIC PPO, KPIC OOA, and KPIC dental plans)

**Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC dental plans.*

☐ Check here if sending additional page(s).

ENROLLMENT FORM

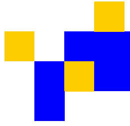
If additional room for dependents is not needed, there is no need to complete or fax this page.

Employee name ____________________ Company name ____________________ ____/____/____ Date coverage to be effective

Group number ____________________ Plan selection ____________________

E **Family information** (additional dependents)

☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no. ______
Name (Last, First, MI) ______			Medical record no. *(if known)* ______
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no. ______
Name (Last, First, MI) ______			Medical record no. *(if known)* ______
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no. ______
Name (Last, First, MI) ______			Medical record no. *(if known)* ______
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no. ______
Name (Last, First, MI) ______			Medical record no. *(if known)* ______
☐ Child	Date of birth	Gender ☐ M ☐ F	Social Security no. ______
Name (Last, First, MI) ______			Medical record no. *(if known)* ______



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	Bank 2	Bank 3
Routing # Check # Account #	Routing # Account # Check #	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:	$ ____________________

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.

Special Programs Included in your Kaiser Premium through the Benefits Store Association Plans

Association Special Discount Dental Plan

CREBPT Kaiser Members Special Discount Dental Plan gives you immediate, predictable and significant discounts for dental services. Because the Special Discount Dental plan is not insurance, plan members decide when to use a participating dentist, how often, and without any limit on their savings. For additional plan information and a list of providers please go to www.NewDentalChoice.com.

Association Special Life Insurance Plan

The primary insured member will receive $10,000 Life and AD&D coverage automatically as part of your enrollment with the Benefits Store. This coverage is provided by Mutual of Omaha. You may be able to purchase additional coverage at very competitive rates without any health question for yourself and eligible family members.

Benefits Store, Inc.
P.O. Box 238
Alamo, CA 94507

Phone: 800-446-2663
Fax: 925-855-2051
E-mail: Jake@BenefitsStore.com
CA INS Lic#0680704

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Association Benefits