PacifiCare DHMO DENTAL 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 ____________________

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:

[ ] PacifiCare DHMO

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.

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PREMIUM PAYMENTS:

(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 Dental 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.

Enrollment / Change of Status Form

PacifiCare® Dental & Vision

IMPORTANT: See other side for instructions. Please print neatly and complete all sections.

1. Purpose of Form

Check One:
- ☐ Open Enrollment
- ☐ New Hire
- ☐ Re-Hire
- ☐ Change of Status

Important: *For Change of Status, this form will supersede all previous enrollment forms; please indicate all coverage you wish to begin or continue.*

For Change of Status, Check One:
- ☐ Name Change
- ☐ Provider Change
- ☐ Address Change
- ☐ Telephone Change
- ☐ Plan Change
- ☐ Dependent Change (Add or Remove)
- ☐ Enrollee (+Dependent) Removal

For Dependent Change,
Group Administrator must submit form to PDVA within 31 days of Qualifying Event.
Date of event: __ __ / __ __ / __ __

Check One:
- ☐ Marriage
- ☐ Newborn
- ☐ Divorce
- ☐ Other
- ☐ Legal Guardianship
- ☐ Loss of Coverage
- ☐ Adoption/Placement

Employer Use Only

Company Name

Group Number

Enrollee's Effective Date __ __ / __ __ / __ __

Plan Name (Dental/Vision)

Employer Verification Signature

2. Enrollee * Please Note: Dental Benefit Providers of California, Inc. Is referred to "DBP-CA"

Last Name

Date of Hire __ __ / __ __ / __ __

First Name

MI

Date of Birth __ __ / __ __ / __ __

Sex ☐ M ☐ F

Social Security Number ___ - __ - ____

Mailing Address

Apt # (or secondary address information)

City

State

Zip

Home Phone # ( ) -

Work Phone # ( ) -

Spouse's Insurance Carrier (if applicable)

Effective Date of Spouse's Insurance __ __ / __ __ / __ __

Have you had any dental coverage within the last 60 days? ☐ Yes ☐ No

For DBP-CA SignatureValue Provider Group Number / Dentist's Name/City

Existing Patient? ☐ Yes ☐ No

3. Selected Coverage

Select only plans offered by your employer.
Important: *For Change of Status, this form will supersede all previous enrollment forms; please indicate all coverage you wish to begin, continue, or remove.*

Dental Plan Options:
- ☐ DBP-CA SignatureValue*
- ☐ DBP-CA SignatureIndependence* (OR/WA)
- ☐ Remove Dental

Individual(s) to be covered:
- ☐ Self ☐ Self + Spouse
- ☐ Self + Child(ren) ☐ Self + Family

Family means spouse and child(ren).

Vision Plan Options:
PacifiCare SignatureOptions*
- ☐ Full Service ☐ Remove Vision
- ☐ Eyewear Only
- ☐ Exam Only

Individual(s) to be covered:
- ☐ Self ☐ Self + Spouse
- ☐ Self + Child(ren) ☐ Self + Family

Family means spouse and child(ren).

For a list of DBP-CA SignatureValue dental Provider Groups in your area, visit **www.pacificare-dental.com** or check with your group administrator.

4. Dependents ☐ For Additional Dependents, check here and attach additional sheet.

1

Last Name / First Name / MI

☐ Add ☐ Remove

Relationship:
- ☐ Spouse
- ☐ Domestic Partner
- ☐ Daughter
- ☐ Son

Date of Birth __ __ / __ __ / __ __

Sex ☐ M ☐ F

Social Security Number ___ - __ - ____

For DBP-CA SignatureValue Provider Group Number / Dentist's Name/City

Existing Patient? ☐ Yes ☐ No

2

Last Name / First Name / MI

☐ Add ☐ Remove

Relationship:
- ☐ Spouse
- ☐ Domestic Partner
- ☐ Daughter
- ☐ Son

Date of Birth __ __ / __ __ / __ __

Sex ☐ M ☐ F

Social Security Number ___ - __ - ____

DBP-CA SignatureValue Provider Group Number / Dentist's Name/City

Existing Patient? ☐ Yes ☐ No

3

Last Name / First Name / MI

☐ Add ☐ Remove

Relationship:
- ☐ Spouse
- ☐ Domestic Partner
- ☐ Daughter
- ☐ Son

Date of Birth __ __ / __ __ / __ __

Sex ☐ M ☐ F

Social Security Number ___ - __ - ____

For DBP-CA SignatureValue Provider Group Number / Dentist's Name/City

Existing Patient? ☐ Yes ☐ No

X I understand and agree to the terms and conditions on the reverse side of this sheet.

Enrollee Signature ______________________ Date ________

* PacifiCare SignatureOptions and PacifiCare SignatureIndependence plans underwritten by PacifiCare Life Assurance Company, except in California where underwritten by Dental Benefit Providers of California, Inc. PacifiCare SignatureValue plans offered by Dental Benefit Providers of California, Inc.

Return completed form to your Group Administrator.

Instructions for completing this Form

1) **Check all appropriate boxes and print all information clearly:** It is important that you check all appropriate boxes. Be sure to indicate whether you are enrolling for the first time or changing your information.
2) **Enrollee:** This section must always be filled out completely. If you are on a Dental Benefit Providers of California, Inc. ("DBP-CA") SignatureValue dental plan, remember to indicate the **DBP-CA SignatureValue Dental Provider Group number/dentist/city** you have selected.
For a list of Provider Groups in your area, visit www.pacificare-dental.com or check with your Group Administrator.
3) **Selected Coverage:** Please indicate the plan(s) in which you are enrolling or continuing. Not all plans are available to all groups or in all states. Your Group Administrator will know which plans are available to you. Select only plans offered by your employer.
4) **Dependents:** All dependents you wish to be covered should be listed in this section. If your dependents are on a DBP-CA SignatureValue dental plan, remember to indicate their **DBP-CA SignatureValue Dental Provider Group number/dentist/city** selections.
5) **Refusal of Employee and/or Dependent Coverage:** If you do NOT wish coverage for either yourself or dependents, please complete and sign the **Refusal of Employee and/or Dependent Coverage Insurance** (available from your Group Administrator).
6) **Changing information:** If you are changing information previously submitted, please enter the changed information in the appropriate section. Be sure to mark the reason you are changing information in the box labeled "**For Change of Status**" at the top of the form.
7) **Terms and Conditions:** Read the **Terms and Conditions** below and sign in the box on the front at the "X." **This form must be signed for coverage to be effective.**
8) **Return completed form to your Group Administrator. This form cannot be processed if information is incomplete.**

Enrollment/Change of Status - Checklist

This form cannot be processed if information is incomplete and will be returned. Please use this checklist to include all necessary information to process your enrollment form.

Enrollee:

- ☐ Signature
- ☐ Social security number
- ☐ Address
- ☐ Date of birth
- ☐ Provider Group selection
(for DBP-CA SignatureValue dental plans)

Group Administrator:

- ☐ Company name
- ☐ Group number
- ☐ Enrollee's effective date of coverage
- ☐ Plan name (for example: V142, E450, I810)
- ☐ Employer verification signature

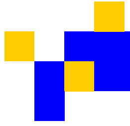
Terms and Conditions

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

I agree and understand that any and all disputes, including claims of dental or vision malpractice (that is as to whether any dental or vision services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims to ERISA, between myself and DBP-CA and PacifiCare Vision Administrators, 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 state law provides for judicial review of arbitration proceedings. Both parties to this agreement 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 binding arbitration.

Group Administrator, please mail completed form to:
Attn: Employer Groups, MAS, LC05-342
Dental Benefit Providers of California, Inc. and PacifiCare Vision Administrators
P.O. Box 25187
Santa Ana, CA 92799-5187

Phone (714) 513-6494
or 1-800-622-6388, option #4



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.