# 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 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.**

# 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.

UnitedHealthcare Vision℠

TO BE COMPLETED BY BENEFITS OFFICE:
Effective Date: _____/_____/_____
Sub Code: _____ Client Code:_____
G/L Account: _____

# Vision Plan Enrollment Form

Organization Name:_____

## I. Check the Appropriate Boxes

**Coverage Desired**

- ☐ Employee Only $_____
- ☐ Employee + Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee + Family $_____

- ☐ New Enrollment
- ☐ Change of Status/Address
- ☐ Open Enrollment
- ☐ COBRA

**REASON FOR CHANGE IN STATUS**

- ☐ Termination
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Move to COBRA
- ☐ Death
- ☐ Divorce
- ☐ Last Name/Address Change
- ☐ Adoption/legal custody of child
- ☐ Legal custody of parent
- ☐ Dependent child married/reached age limit

## II. Employee Information (please print clearly):

Unique Member ID Number _____ - _____ - _____

Your Name _____
(First) (Middle Initial) (Last)

Birth Date _____/ _____/ _____

Address _____

_____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

## III. List All Eligible Family Members Below (if electing dependent coverage):

| | First Name | Last Name | Birth Date | Full Time Student? | Sex |
|---|---|---|---|---|---|
| Spouse | | | / / | not applicable | ☐M / ☐F |
| Child | | | / / | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | | / / | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | | / / | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | | / / | ☐ Yes ☐ No | ☐M / ☐F |

*I agree to continue enrollment in the vision plan for a period of 12 months*
*Your Signature*_____ *Date*_____

Spectera, Inc. administers vision benefits underwritten by the following entities United HealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York (NY only).

# 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

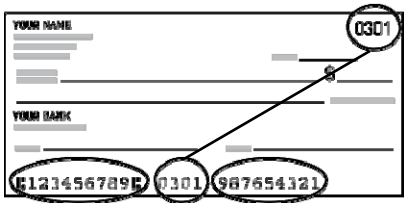
**Name on Account:** **Name of Financial Institution:**

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

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

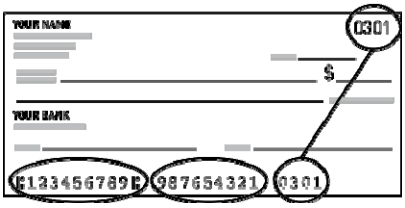
***Determining your routing number:***
**To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on you company check varies depending on your bank; for example:**

**Bank 1**



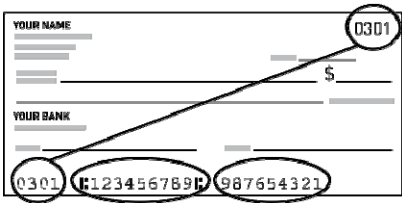

**Routing # Check # Account #**

**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.