

KAISER*
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.

W2 Employees of a member firm – Please call our office at 1-800-446-2663

**SELECTING
YOUR PLAN:**

[] \$5 co-pay [] \$15 co-pay [] \$20 co-pay [] \$30 co-pay [] \$50. co-pay
[] \$30. co-pay / \$1000 ded [] \$30. co-pay / \$1500 ded
[] \$30. co-pay / \$2700 ded HSA

**COMPLETING THE
APPLICATION:**

USE BLACK INK AND COMPLETE PARTS 1 & 2 AND SECTIONS A, B, & C ONLY (DO NOT COMPLETE THE EMPLOYER SECTION) See instructions.

**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 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 - KAISER
Benefits Store, Inc.
PO Box 68, Orinda, CA 94563-0068

OVERNIGHT/EXPRESS DELIVERY ONLY

ATTN: ENROLLMENT - KAISER
Benefits Store, Inc.
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

KAISER*

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 or MasterCard**

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

APPLICATION PROCESSING:

Allow 12 business days for the processing of your application and for you to appear in Kaiser's database. **DON'T DELAY – ENROLL TODAY!** ID Card(s) (from Kaiser) 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 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, E-mail: Enrollment@BenefitsStore.com

ADDITIONAL INFORMATION – PLEASE READ

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 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 1 business day (M-F) BEFORE the last business day of the month in which you wish to cancel. For example, April 29, 2008 for an effective cancellation date of April 1, 2008.

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.

*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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ENROLLMENT INSTRUCTIONS

APPLICATION INSTRUCTIONS

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

DO NOT Complete -*Company Name, Group Account Number, Enrollment Unit, Plan Description, Employee Classification, or Date of Hire* - we will complete this information.

Complete Enrollment Reason Section.

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

SECTION B **Complete** – **Family Information.** The subscriber must complete all fields for any dependents being enrolled. The student role should only be marked if the dependent qualifies as an overage dependent attending school. Please contact The Benefits Store regarding the rules for coverage for dependent students. A completed Student Certification Form will be required.

Please check “Yes” or “No” boxes to indicate whether or not you will need Page 2, Section D to list additional dependents.

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

PAGE 2
SECTION D **Complete** – If you are listing additional dependents.

PAGE 2 **Complete** - **Selecting Coverage.** Remember, you must choose one (1) from the following eight (8) plans.

**SELECTING
COVERAGE**

Kaiser Co-Pay Plans:

\$5 co-pay \$15 co-pay \$20 co-pay \$30 co-pay \$50 co-pay

Kaiser Deductible Plans:

\$30 co-pay / \$1000 deductible \$30 co-pay / \$1500 deductible

Kaiser HSA Compatible Plan:

\$30. co-pay / \$2700 deductible HSA

Enrollment form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

To be completed by EMPLOYER

New group account

Existing group account

Company name*

Group account number

Enrollment unit

Plan description

Employee classification (if applicable)

Employee name

Date of hire

Date coverage to be effective*

*Enrollment reason (Please check one.)

New group account

New hire

Open enrollment

Part time to full time

Loss of coverage

Other

Event date

To be completed by EMPLOYEE

A Are you now or 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 (optional)

Preferred spoken or written language (optional)

Home address*

Apt no.

City

State

ZIP

Date of birth*

Gender* M F

Home phone*

Work phone

B Family Information

Spouse Domestic partner

Date of birth

Gender*
 M F

Social Security no. or medical record no.

Name (Last, First, MI)

Child Student

Date of birth

Gender*
 M F

Social Security no. or medical record no.

Name (Last, First, MI)

Child Student

Date of birth

Gender*
 M F

Social Security no. or medical record no.

Name (Last, First, MI)

Child Student

Date of birth

Gender*
 M F

Social Security no. or medical record no.

Name (Last, First, MI)

Please see next page for additional dependents if needed. Will you be adding additional dependents on page 2? Yes No

C Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for small claims court cases, claims subject to a Medicare appeals procedure, and, if my group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, my relatives, or other associated parties on the one hand and the Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Health Plan, 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.

X _____
Employee/Applicant signature* (Use black ink only.)

_____ / _____ / _____
Date*

(continues)

Enrollment form (continued)

Employee name _____	Company name* _____	Date coverage to be effective* _____/_____/_____
Group number _____	Plan selection _____	

D Family information (additional dependents)

<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			
<input type="checkbox"/> Child <input type="checkbox"/> Student	Date of birth _____	Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Social Security no. or medical record no. _____
Name (Last, First, MI) _____			

Choose Your Coverage.

Remember, you must choose one (1) from the following eight (8) plans.

Kaiser Co-Pay Plans:

\$5 co-pay \$15 co-pay \$20 co-pay \$30 co-pay \$50 co-pay

Kaiser Deductible Plans:

\$30. co-pay / \$1000 deductible \$30. co-pay / \$1500 deductible

Kaiser HSA Compatible Plan

\$30. co-pay / \$2700 deductible HSA Compatible

BENEFITS STORE, INC.

CA Insurance License #0680704

IMPORTANT NOTICE

NEW CUSTOMER SERVICE ACCESS FOR MEMBERSHIP ACCOUNTING AND BILLING QUESTIONS

PHONE NUMBER: (925)725-0333

FAX: (925)855-2051

EMAIL: BILLING@BENEFITSSTORE.COM

MAILING ADDRESS: BENEFITS STORE/ MEMBERSHIP ACCOUNTING

PO Box 68

ORINDA, CA 94563-0068

Electronic Funds Transfer (EFT)

Premiums are payable in advance of the month of coverage.

RELIABLE!

EFT is a method of automatically withdrawing or depositing funds to an individual's bank account.

SAFE!

All EFT transactions are tracked and governed by the Federal Reserve. Only preauthorized transactions are allowed to be processed.

EASY TO USE!

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.

Lockbox # 30565

PO Box 60000

San Francisco, CA 94160-0001

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.Washingtonmutual.com

[WAMU - 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.

Lockbox # 30565

PO Box 60000

San Francisco, CA 94160-0001

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 and MasterCard for monthly premium payments,

To use this payment option, a convenience fee of 2.5% of your premium amount will be charged.

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.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I authorize Benefits Store, Inc. to initiate periodic deductions from my account shown below.

<p><u>ATTACH YOUR PREMIUM CHECK HERE!!!</u></p>
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I understand this authority is to remain in full force and effect until Benefits Store, Inc. has received a written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to Benefits Store, Inc. twenty (20) business days or more before this payment is scheduled to be made.

Choice of Payment Dates – [] 5th or [] 15th of each Month

A \$5.00 Service Charge may be added for any item returned by the bank.

Signature of Depositor _____ Date _____

For Benefits Store, Inc. Use Only

Account Information

Policy Holder Name: _____

Policy Number _____

Deduction Amount \$ _____

Initial Month on the 5th/15th day of _____

Once a Month beginning on the 5th/15th day of _____