

PacifiCare*
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 – Please call out office at 800-446-2663

IMPORTANT!!!

**PPO
APPLICANTS
ONLY!!!**

Can you show proof of current medical coverage? [Yes [No

If “Yes”, you must attach a copy of your current Membership Card to your application.
If “No”, you must call our office at 1-800-446-2663 prior to completing your application.

**SELECTING
YOUR PLAN:**

- [] HMO \$10 PCP* Co- Pay
 - [] HMO \$20 PCP* Co-pay
 - [] HMO \$20 PCP* Co-pay - \$1500 Deductible
 - [] PPO \$35 Co-Pay - \$1000 Deductible
- *PCP – Primary Care Physician

**COMPLETING THE
APPLICATION:**

USE BLACK INK AND COMPLETE SECTIONS 1 THROUGH 5 ONLY.
(DO NOT COMPLETE THE EMPLOYER SECTION)

**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.

**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.

PacifiCare*

ENROLLMENT INSTRUCTIONS

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

OVERNIGHT/EXPRESS DELIVERY ONLY
ATTN: ENROLLMENT - PACIFICARE
Benefits Store, Inc.
85 High Eagle Road, Alamo, CA 94507-2009

PREMIUM PAYMENTS:

You have four (4) ways to pay your monthly premium:

- **Electronic Funds Transfer (EFT)**
- **Monthly Invoice/Check**
- **On-Line Bill Payment through your Financial Institution**
- **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 PacifiCare's database. **DON'T DELAY – ENROLL TODAY!** ID Card(s) (from PacifiCare) 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.

IMPORTANT!!!

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.

PacifiCare*

ENROLLMENT INSTRUCTIONS

APPLICATION INSTRUCTIONS

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

DO NOT Complete – “Employer Required to Complete This Section” box at top of page

SECTION 1 **DO NOT Complete** - Company Name, Occupation/Title, Date of Hire, Date of Rehire - we will complete this information.

Complete all of the Personal Information questions.

SECTION 2 **Complete** - Selecting Coverage. Remember, you may only choose from the following four (4) plans, other plans shown on the application are NOT available:

PacifiCare Signature Value (HMO) Plans

Signature Value \$10 PCP CO-PAY*

Signature Value \$20 PCP CO-PAY*

Signature Value \$20 PCP CO-PAY WITH \$1,500 DEDUCTIBLE*

*PCP – Primary Care Physician

Shown on Application as

10-30/100

20-40/500d

20/1500ded

PacifiCare Signature Elite (PPO) Plans

Signature Elite \$35 Co-Pay - \$1,000 DED PPO Plan

Shown on Application as

35/70-50/1000

SECTION 3 **Complete** - Employee & Dependent Information.

SECTION 4 **Complete** - Benefits Coordination/Other Insurance Carrier Information If you are going to continue your own coverage or have current on-going treatment, make sure to include this information.

SECTION 5 **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.

NOTE: IMPORTANT (PPO APPLICANTS ONLY)

If you do not have current coverage, you must contact us for an explanation of pre-existing condition coverage before enrolling in a PPO plan. Contact Roger Smith by e-mail at Roger@BenefitsStore.com or (800) 446-2663.

For those with current coverage, when applying for a PPO plan, make sure you enclose a copy of your I.D. card from your current coverage. You will also need to provide us (and PacifiCare) with a copy of the HIPAA letter from your current insurer as proof of “prior, credible coverage”. HIPAA letters are generally sent to you approx. 3 weeks after you cancel your current coverage and provide proof to your new insurer of your prior coverage. When you receive your HIPAA letter, fax a copy to our offices at (925) 855-2050.

Make sure to include your PacifiCare Subscriber Number (from your PacifiCare ID Card) on the HIPAA (Letter of Credible coverage) form.

Employee Enrollment Form (Please Print) Revised 11/07

CALIFORNIA

Employer Required to Complete This Section			
Group #/Plan Code	Reason for Application: <input type="checkbox"/> QMCSO <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Group Plan <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire	Employee Type: <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Other _____	Requested Effective Date

1. Personal Information				
Company Name		Occupation/Title		Date of Hire
Last Name		First Name	MI	Suffix <input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Mailing Address			City	State ZIP
Number of hours you work in a normal week:	Have you or any of your dependents ever been a PacifiCare Member? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Telephone () ()	Work Telephone () ()	
Date of Birth (mm-dd-yy)	Social Security #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		
Are you currently on COBRA or Cal-COBRA? If yes, qualifying event and original start date: <input type="checkbox"/> Yes <input type="checkbox"/> No	Annual Salary	Would you like to receive information via e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	E-mail	
Ethnicity (Optional) <input type="checkbox"/> Caucasian <input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian, Native Hawaiian, other Pacific Islander		Preferred Language (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____

2. Selected Coverage (Select only the plans offered by your Employer)																										
Medical Plan Options	Supplemental Plan Options																									
PacifiCare SignatureValue (HMO) and PacifiCare SignatureValue Advantage (HMO) <table border="0"> <tr> <td></td> <td>HMO</td> <td>HMO Advantage</td> </tr> <tr> <td>10-30/100</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>15-30/250a</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>10/500d</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>20-40/500d</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>35/600d</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>20/1500ded</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>40-60/2000ded</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		HMO	HMO Advantage	10-30/100	<input type="checkbox"/>	<input type="checkbox"/>	15-30/250a	<input type="checkbox"/>	<input type="checkbox"/>	10/500d	<input type="checkbox"/>	<input type="checkbox"/>	20-40/500d	<input type="checkbox"/>	<input type="checkbox"/>	35/600d	<input type="checkbox"/>	<input type="checkbox"/>	20/1500ded	<input type="checkbox"/>	<input type="checkbox"/>	40-60/2000ded	<input type="checkbox"/>	<input type="checkbox"/>	PacifiCare SignaturePOS (POS) <input type="checkbox"/> 15/80-60 PacifiCare SignatureElite (PPO) <input type="checkbox"/> 15/90-50/250 <input type="checkbox"/> 20/80-60/250 <input type="checkbox"/> 30/70-50/250 <input type="checkbox"/> 35/80-60/500 <input type="checkbox"/> 35/70-50/1000 <input type="checkbox"/> 35/50-50/1000 <input type="checkbox"/> 70-50/2000 <input type="checkbox"/> 70-50/3500	<input type="checkbox"/> Life (Additional Enrollment Form required) Dental Plan Option <input type="checkbox"/> PacifiCare SignatureValue (Dental HMO) Vision Plan Options <input type="checkbox"/> PacifiCare SignatureOptions (Dental PPO - Full Service) <input type="checkbox"/> PacifiCare SignatureOptions (Dental PPO - Eyewear Only)
	HMO	HMO Advantage																								
10-30/100	<input type="checkbox"/>	<input type="checkbox"/>																								
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40-60/2000ded	<input type="checkbox"/>	<input type="checkbox"/>																								

Please complete the Declination of Coverage form if declining coverage for Self and/or Eligible Dependent(s)

3. Employee & Dependent Information (List yourself and family members to be covered - attach additional sheets if necessary)				
Self	Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist Name and City		Dental Provider Group #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/ Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I.
Date of Birth (mm-dd-yy)	Social Security #	Address, if different than Employee's		
Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City		Dental Provider Group #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I. Date of Birth (mm-dd-yy)
Relationship	Social Security #	Address, if different than Employee's		
Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City		Dental Provider Group #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I. Date of Birth (mm-dd-yy)
Relationship	Social Security #	Address, if different than Employee's		
Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City		Dental Provider Group #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3	<input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name	First Name	M.I. Date of Birth (mm-dd-yy)
Relationship	Social Security #	Address, if different than Employee's		
Primary Care Physician (PCP) Name		Provider #	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentist Name and City		Dental Provider Group #		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Check box if additional enrollment page is attached for dependents.

Detach here

Group # _____

Employee Name _____

Social Security # _____

4. Benefit Coordination/Other Insurance Carrier Information

Do you or any of your Dependents have any other health insurance? Yes No
If yes, will this coverage remain in effect if this application is accepted? Yes No If yes, complete boxes a-j:

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address
f. Name	g. Insurance Company Name	h. Policy #	i. Effective Date	j. Other Employer Name and Address

Is anyone listed permanently disabled? Yes No If yes, complete boxes k + l:

k. Name	l. Date Disability Began
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Is anyone listed eligible for Medicare? Yes No If yes, complete boxes m + n:

m. Name	n. Medicare ID#
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Does anyone listed have other dental insurance? Yes No If yes, complete boxes o - r:

o. Name	p. Insurance Company Name	q. Policy #	r. Effective Date
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5. Signature Required for Terms and Conditions and Arbitration Disclosure – Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions and Arbitration Disclosure on all pages of this form. A reproduction of this authorization shall be as valid as the original.

I. I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.

II. ARBITRATION DISCLOSURE: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES 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 THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL 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.

Signature (Required) X	Date (Required)
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Detach here

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 \$ _____

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

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