

Baird & Warner

2010 Group Enrollment Processing

Thank you for choosing **Dergalis Associates**, leaders providing benefit programs for the real estate professional. In order to ensure proper processing of your application, you will need to follow these instructions carefully.

1. Once you have selected the plan(s) in which you wish to enroll, print and complete the corresponding application(s).
2. Make sure you have signed and completed the application(s) in their entirety. Check them for any errors or missing information.
3. Review, complete and sign the **Automatic Deduction Agreement** form.
4. Make a **photocopy** of your **voided check** for the account from which you would like the premium deduction to take place and include it with your forms. Remember, all bank account deductions will take place on the 1st business day of every month. If we are unable to draft your account on this day, you may be subject to fees as outlined in the Automatic Deduction Agreement.
5. **Fax** your applications with the **Automatic Deduction Agreement** and the **voided check** to the Insurance Department fax number shown below. **We MUST have all applications by the posted due date or coverage cannot become effective!**

Please call us with any questions that you have during the enrollment process.

Dergalis Associates
Insurance Department

9 East Stow Road, Suite A
Marlton, NJ 08053

Toll Free Phone: (888) 564-0300

Fax: (856) 396-3193

insurance@agentbenefits.net

Dergalis Associates Frequently Asked Questions

1. Must I take all of the benefits?

No, each benefit can be purchased individually.

2. Will I get another opportunity to enroll if I decline to take coverage now?

Once a year, the group dental and vision plans will have open enrollment. However, the disability and life insurance will NEVER be offered again on a guaranteed basis. While you can apply at a later date, you will undergo limited underwriting and the carrier will have the right to decline you coverage based on the results.

3. What if I do not need dental or vision because it is provided for me through my spouse or another source? Will I be able to come back into the program if I loose that coverage mid year?

Yes, you will have the opportunity to enroll within 30 days of a qualifying life event such as a birth, death, divorce or loss of coverage. For more information on what constitutes a qualifying life event, please contact our office.

4. Can I pay a different way other than Automatic Deduction from my checking account?

We currently accept Visa, MasterCard, or Discover for premium payments. Please contact our office at (888) 564-0300 for more information. Additionally, you can use a savings account as long as you provide us with a deposit slip imprinted with your name, bank account number, and bank routing number.

5. When and how will I receive confirmation of my coverage?

You should receive an email from our offices as well as confirmation in the mail to your address on the application within 3 weeks.

6. What if I have an emergency before I receive proof of coverage?

In the event you have an emergency situation, you should contact Judy King at 1-800-265-2876 x11328. Judy will help you in the transition period.





CONCORDIA FLEX Dental Benefits Summary for Baird & Warner

Network: Advantage Plus

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

Benefit Category²	Plan Pays¹
Class I – Diagnostic/Preventive Services	
Exams	100%
Cleanings & Fluoride Treatments	
X-rays	
Sealants	
Space Maintainers	
Palliative Treatment (Emergency)	
Class II – Basic Services	
Basic Restorative (Fillings, etc.)	100%
Simple Extractions	
Endodontics	
Oral Surgery	
General Anesthesia	
Repairs to Inlays, Onlays and Crowns and Prosthetics	
Class III – Major Services	
Surgical & Non-surgical Periodontics	70%
Inlays, Onlays, Crowns	50%
Prosthetics (Bridges, Dentures)	
Orthodontics (dependents to age 19)	
Diagnostic, Active, Retention Treatment	50%
Program Maximums/Deductibles	
Annual Program Maximum (per covered person)	\$2,000
Lifetime Orthodontic Maximum (per covered person)	\$1,500
Annual Program Deductible (per person/per family)*	\$50/\$150
Non-network Reimbursement	Advantage MAC

*Annual Deductible excludes Class I Services

- The listed network percentages represent the portion of United Concordia's maximum allowable charges (MACs) for which the plan will be responsible. Network providers agree to accept United Concordia's MAC for covered services as payment in full and also agree to file claims for you. If you or your family members receive services from a non-network provider, United Concordia will apply the percentages shown to the [non-network reimbursement] for covered services and you will be responsible for the difference, up to the provider's charge. United Concordia's standard exclusions and limitations apply.
- Unmarried dependent children covered to age 19. Unmarried dependent students covered to age 25. Disabled dependents covered to any age.

Monthly Rates Effective 1/1/10 to 12/31/10	
Single	\$50.64
Husband/Wife	\$111.74
Parent/Child	\$122.40
Parent/Children	\$155.86
Family	\$155.86

Provider information available at www.ucci.com. The network of providers for this program is **Advantage Plus**.

**BAIRD & WARNER
UNITED CONCORDIA DENTAL & DAVIS VISION
ENROLLMENT FORM**

COMPANY NAME: _____

EFFECTIVE DATE: _____

NAME: _____

DATE OF HIRE: _____

ADDRESS: _____

SS# _____

PHONE: _____

EMAIL: _____

DATE OF BIRTH: _____

GENDER: _____

A. Please check all coverage(s) you are applying for: _____ DENTAL _____ VISION

B. Please indicate who will be insured under the policy (check only ONE):

_____ Applying for single coverage for myself _____ Applying for MYSELF & DEPENDENTS LISTED BELOW

C. ENROLLMENT INFORMATION (complete if including coverage for dependents)

NOTE: Use separate Dental and Vision applications if you want to enroll dependents on one plan and not on the other.

Name	SS#	Date of Birth	Gender
Spouse			M F
Son			
Daughter			M F
Son			
Daughter			M F
Son			
Daughter			M F

I represent that all information supplied in the application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

Signature

Date

Automatic Deduction and Notification Agreement

I hereby authorize **Realty Benefit Services, an affiliate of Dergalis Associates**, to access my checking and/or savings account solely for the purpose of paying premiums for the insurance benefits that I select. The deductions could include health, dental, vision, life and / or disability insurance premiums.

I understand that these deductions will be made periodically and I realize that changes in premiums may result in higher or lower deductions. I further understand that I shall incur additional charges in the event this debit is returned for any reason. In the event that **Realty Benefits Services** is unable to collect my premiums on the first business day of the month, I will be charged \$25.00.

Notifications

I agree to provide signed written notice at least two weeks in advance in the event I wish to cancel, change or amend my current policies. I further agree to indemnify and hold harmless **Realty Benefit Services, an affiliate of Dergalis Associates**, for charges assessed on my account from my lending institution due to debits for services rendered. I agree to notify **Realty Benefit Services, an affiliate of Dergalis Associates**, in writing of any changes to my bank account. This notice will be at least two weeks in advance of any scheduled payment debits.

I understand that these services are being provided solely through arrangements with **Realty Benefit Services, an affiliate of Dergalis Associates**, my real estate firm and the insurance carrier. I am aware that I must notify **Dergalis Associates** in writing if I no longer work as a licensed Realtor with my current Real Estate firm. This notification is my responsibility, otherwise, **Dergalis Associates** will NOT be able to notify our COBRA administrator, to offer me COBRA benefits, if applicable. If I do NOT notify **Dergalis Associates** within 30 days of my termination, I realize I may continue to get billed for services and benefits that I am no longer eligible to receive and I may forfeit any benefits received or premiums I paid for these benefits beyond my termination date. **NO REFUNDS WILL BE PROVIDED FOR MY FAILURE TO NOTIFY DERGALIS ASSOCIATES OF TERMINATION OR SEPARATION FROM MY REAL ESTATE COMPANY.** I understand that any changes to or termination of my coverage will also affect the coverage I have elected for my dependents.

I have read and accept the terms of the above notification agreement.

SIGNATURE OF INSURED X

NAME OF INSURED _____ SS # _____

REALTY COMPANY _____ OFFICE NAME _____

WORK EMAIL _____ PERSONAL EMAIL _____

WORK PHONE _____ FAX # _____

HOME ADDRESS _____

HOME PHONE _____ CELL PHONE _____

SIGNATURE X _____ DATE _____

OF ACCOUNT OWNER*

*Note: Signature should be that of the owner of the checking account whose name appears on the check used for deductions.

ATTACH VOIDED CHECK

ATTACH YOUR BUSINESS CARD