

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 lose 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.



Information about Laser Vision Correction Services:

Davis Vision is pleased to provide you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at significant discounts through a network of experienced, credentialed surgeons (please note that some providers have flat fees equivalent to these discounts). For more information, please visit our website at www.davisvision.com or call 1-800-999-5431.

Information about Low Vision Services:

You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up care visits will be covered during the five year period.

What about out-of-network provider benefits?

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

**Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110**

To request claim forms, please visit the Davis Vision website at www.davisvision.com or call 1-800-999-5431.

What lenses/coatings are included?

- Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range.
- Oversize lenses.
- Post-cataract lenses.
- Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

Are there any optional frames, lens types or coatings available?

Yes, you can pay the low, discounted fixed fees indicated and receive these exciting optional items:

- \$15.00 for a Designer frame from "The Collection".
- \$40.00 for a Premier frame from "The Collection".
- \$35.00 for polycarbonate lenses.
- \$20.00 for scratch-resistant coating.
- \$15.00 for fashion and gradient tinting of plastic lenses
- \$15.00 for glass-grey #3 prescription sunglasses
- \$20.00 for Photogrey Extra® (photosensitive) glass lenses.
- \$15.00 for ultraviolet (UV) coating.
- \$40.00 for standard ARC (anti-reflective coating). Premium ARC is \$55.00. Ultra ARC is \$69.
- \$75.00 for polarized lenses.
- \$30.00 for intermediate vision lenses.
- \$20.00 for blended invisible bifocals.
- \$70.00 for plastic photosensitive lenses.
- \$60.00 for high-index (thinner and lighter) lenses.
- \$65.00 for standard progressive addition multifocal lenses. Premium progressive additional lenses are \$105.00**

*** Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive addition lenses; however, the copayment will not be refunded.*

Information about Mail Order Contact Lenses:

Free membership and access to a mail order replacement contact lens service, Lens 123, providing a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the Lens 123 website at www.Lens123.com.

For additional information:

Please call Davis Vision at 1-800-999-5431 with questions or visit our website: www.davisvision.com. Member Service Representatives are available: Monday through Friday, 8:00 AM to 8:00 PM, Eastern Time, and; Saturday, 9:00 AM to 4:00 PM Eastern Time. Participants who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling 1-800-523-2847.

Your rights as a patient:

Davis Vision recognizes that all patients have specific rights, including, but not limited to:

- The right to complete information about their healthcare options and consequences.
- The right to participate in all treatment decisions.
- The right to dignity, privacy, confidentiality and non-discrimination.
- The right to complain or appeal any decision.

Patients also have the responsibility:

- To provide complete and accurate information.
- To follow care instructions.

For a complete copy of *Your Rights and Responsibilities As a Patient*, please visit our website at: www.davisvision.com or call 1-800-999-5431.

**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