Dergalis ASSOCIATES

Group Enrollment Processing

In order to ensure proper processing of your applications, please read the following 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 each 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 application 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 you have during the enrollment process.

Group Insurance
Benefits Administrator

P: (888) 564-0300, toll free
F: (856) 396-3193
E: insurance@agentbenefits.net

Dergalis ASSOCIATES

Frequently Asked Questions

Q: Must I take all of the benefits?

A: No, each benefit can be purchased individually.

Q: Will I get another opportunity to enroll if I decline to take coverage now?

A: Once a year, the Group Dental and Vision plans will have an Open Enrollment period. However, the Group Disability and Life Insurance will NEVER be offered again on a Guaranteed-Issue basis. While you can apply at a later date, limited medical underwriting will be required and the carrier will have the right to decline you coverage based on the results.

Q: I currently have other coverage for Dental and Vision. If I lose that coverage, could I participate in your program?

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

Q: Is the Automatic Deduction from my checking account the only way to pay?

A: Please contact our office at (888) 564-0300 for more information. Additionally, you can use a savings account as long as you provide a deposit slip imprinted with your name, bank account number and bank routing number. Please note, we are not set up for individual billing and cannot accept a check as payment.

Q: When and how will I receive confirmation of my coverage?

A: You should receive an email from our office within three weeks. Please make sure to check your junk mail folder if you haven't received the email.

Q: What if I have an emergency before I receive proof of coverage?

A: In the event of an emergency situation, you should contact Group Insurance at (888) 564-0300. Someone will help in the transition period.

Q: Why am I not receiving email communication from the group insurance department?

A: The domain agentbenefits.net may be filtered out by some e-mail providers as "SPAM". Please ensure to update your email address and communication preferences.

Dental Insurance Information

MetLife®

BHHS Fox & Roach | Basic Dental Plan

MetLife

Network: PDP Plus
Benefit Summary

	Basic Plan	
Coverage Type	**In-Network**	**Out-of-Network**
Type A-Preventive	100% of Negotiated Fee*	100% of Negotiated Fee*
Type B-Basic	100% of Negotiated Fee*	100% of Negotiated Fee*
Type C-Major	Not Covered	Not Covered
Type D-Orthodontia	Not Covered	Not Covered
Deductible	**In-Network**	**Out-of-Network**
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit	**In-Network**	**Out-of-Network**
Per Person	$1,750 (Annual Combined)	
Orthodontia Lifetime Maximum	**In-Network**	**Out-of-Network**
Per Person	Not Covered	
Network	**PDP Plus**	

*Negotiated Fee refers to the fees that participating dentists have agreed to accept payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximum. Negotiated fees are subject to change.

Monthly Rates Effective until 1/1/2021 to 12/31/2021

BASIC	COMPREHENSIVE	FREEDOM
Single: $46.80	Single: $68.82	Single: $56.99
Two or More: $126.18	Two or More: $181.24	Two or More: $145.15

There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at **www.metlife.com/dental** or by calling **1-855-700-7993** to have a list faxed or mailed to you on or after your effective date.

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often
Oral Examinations	• Two times in 12 months.
Oral Examinations-Problem Focused	• One time in 12 months.
Oral Examinations-Detailed Problem Focused	• One time in 12 months.
Prophylaxis (cleanings)	• Two times in 12 months.
Topical Fluoride Applications	• Two times in 12 months for a dependent child under age 19.
X-rays	• Full mouth X-rays: one per 36 months. • Bitewing X-rays: one set per calendar year for adults; two sets per calendar year for dependent children under the age of 14.
Sealants	• One application of sealant material every 3 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 16th birthday.
Consultations	• One in 12 months.
Type B - Basic Restorative	**How Many/How Often**
Space Maintainers	• One in 3 years for dependent children up to 19th birthday .
Amalgam Fillings	• One replacement per surface in 12 months.
Resin Composite Fillings (excludes coverage for composite fillings on molars)	• One replacement per surface in 12 months.
Endodontics	• Root Canal treatment limited to one per tooth per lifetime • Pulpotomy, Pulp Capping
Oral Surgery	• Simple Extractions. .
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.

Dental Insurance Information

MetLife®

BHHS Fox & Roach | Comprehensive Dental Plan

MetLife

	Comprehensive Plan	
Coverage Type	**In-Network**	**Out-of-Network**
Type A-Preventive	100% of Negotiated Fee*	100% of Negotiated Fee*
Type B-Basic	100% (70% for Periodontics) of Negotiated Fee*	100% (70% for Periodontics) of Negotiated Fee*
Type C-Major	50% of Negotiated Fee*	50% of Negotiated Fee*
Type D-Orthodontia	50% of Negotiated Fee*	50% of Negotiated Fee*
Deductible	**In-Network**	**Out-of-Network**
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit	**In-Network**	**Out-of-Network**
Per Person	$2,250 (Annual Combined)	
Orthodontia Lifetime Maximum	**In-Network**	**Out-of-Network**
Per Person	$1,500 (Annual Combined)	
Network	**PDP Plus**	

*Negotiated Fee refers to the fees that participating dentists have agreed to accept payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximum. Negotiated fees are subject to change.

Monthly Rates Effective until 1/1/2021 to 12/31/2021

BASIC Single:	**COMPREHENSIVE**	**FREEDOM**
$46.80	Single: $68.82	Single: $56.99
Two or More: $126.18	Two or More: $181.24	Two or More: $145.15

There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at **www.metlife.com/dental** or by calling **1-855-700-7993** to have a list faxed or mailed to you on or after your effective date.

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often – Both Plans
Oral Examinations	• Two times in 12 months.
Oral Examinations-Problem Focused	• One time in 12 months.
Oral Examinations-Detailed Problem Focused	• One time in 12 months.
Prophylaxis (cleanings)	• Two times in 12 months.
Topical Fluoride Applications	• Two times in 12 months for a dependent child under age 19.
X-rays	• Full mouth X-rays: one per 5 calendar years. • Bitewing X-rays: one set per calendar year for adults; two sets per calendar year for dependent children under the age of 14.
Sealants	• One application of sealant material every 3 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 16th birthday.
Consultations	• One in 12 months.
Type B - Basic Restorative	**How Many/How Often – Both Plans**
Space Maintainers	• One in 3 years for dependent children up to 19th birthday .
Amalgam Fillings	• One replacement per surface in 12 months.
Resin Composite Fillings (excludes coverage for composite fillings on molars)	• One replacement per surface in 12 months.
Endodontics	• Root Canal treatment limited to one per tooth per lifetime. • Pulpotomy, Pulp Capping. • Pulp Therapy limited to one per tooth per lifetime.
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Periodontal surgery once per quadrant, every 24 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in 12 months.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Oral Surgery	• Simple and Surgical Extractions.
Repairs	• One in 12 months.
Recementations	• One in 12 months.
Dentures	• Adjustments: one in 12 months.
Type C - Major Restorative	**How Many/How Often – Both Plans**
Prefabricated Crowns	• One per tooth per lifetime.
Crown Buildups/Post Core	• One per tooth in 5 calendar years.
Implants	• Replacement: one per tooth position in 60 months. • Repairs: one per tooth in 12 months. • Supported Prosthetic: one per tooth in 60 months.
Bridges and Dentures	• Dentures and bridgework replacement: one every 5 calendar years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Dentures	• Rebases/Relines: one in 36 months.
Crowns/Inlays/Onlays	• Replacement: one every 5 calendar years per tooth.
Tissue Conditioning	• One in 36 months.
Occlusal Adjustments	• One in 12 months.
Type D - Orthodontia	**How Many/How Often – Freedom w/90% OON & Ortho Plan Only**
	• Your Children, up to age 19, are covered while Dental Insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.

Dental Insurance Information

MetLife®

BHHS Fox & Roach | Freedom Dental Plan

MetLife

Network: PDP Plus
Benefit Summary

	Freedom w/90% OON	
Coverage Type	**In-Network**	**Out-of-Network**
Type A – Preventive	100% of Negotiated Fee*	100% of R&C Fee**
Type B – Basic	80% of Negotiated Fee*	80% of R&C Fee**
Type C – Major	50% of Negotiated Fee*	50% of R&C Fee**
Type D – Orthodontia	Not Covered	Not Covered
Deductible†	**In-Network**	**Out-of-Network**
Individual	$50.00	$50.00
Family	$150.00	$150.00
Annual Maximum Benefit	**In-Network**	**Out-of-Network**
Per Person	$1,500 (Annual Combined)	
Orthodontia Lifetime Maximum	**In-Network**	**Out-of-Network**
Per Person	Not Covered	

*Negotiated Fee refers to the fees that participating dentists have agreed to accept payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximum. Negotiated fees are subject to change.

**R&C Fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same similar services as determined by Metlife.

†Applies only to Type B & C Services.

Monthly Rates Effective until 1/1/2019 to 12/31/2020

BASIC Single:	**COMPREHENSIVE**	**FREEDOM**
$46.80	Single: $68.82	Single: $56.99
Two or More: $126.18	Two or More: $181.24	Two or More: $145.15

There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at **www.metlife.com/dental** or by calling **1-855-700-7993** to have a list faxed or mailed to you on or after your effective date.

Revised 08/27/2019

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often
Oral Examinations	• Two times in 12 months.
Oral Examinations-Problem Focused	• One time in 12 months.
Oral Examinations-Detailed Problem Focused	• One time in 12 months.
Prophylaxis (cleanings)	• Two times in 12 months.
Topical Fluoride Applications	• Two times in 12 months for a dependent child under age 19.
X-rays	• Full mouth X-rays: one per 36 months. • Bitewing X-rays: one set per calendar year for adults; two sets per calendar year for dependent children under the age of 14.
Sealants	• One application of sealant material every 3 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 16th birthday.
Consultations	• One in 12 months.
Type B - Basic Restorative	**How Many/How Often**
Space Maintainers	• One in 3 years for dependent children up to 19th birthday .
Amalgam Fillings	• One replacement per surface in 12 months.
Resin Composite Fillings (excludes coverage for composite fillings on molars)	• One replacement per surface in 12 months.
Endodontics	• Root Canal treatment limited to one per tooth per lifetime • Pulp Therapy limited to 1 per tooth per lifetime. • Pulpotomy, Pulp Capping
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Periodontal surgery once per quadrant, every 24 months. • Periodontal Surgery-Soft & Connective Tissue Grafts once per tooth per lifetime. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in 12 months.
Oral Surgery	• Simple and Surgical Extractions.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Type C - Major Restorative	**How Many/How Often**
Prefabricated Crowns	• One per tooth per lifetime.
Crown Buildups/Post Core	• One per tooth in 5 calendar years.
Repairs	• One in 12 months.
Recementations	• One in 12 months.
Implants	• Replacement: one per tooth position in 60 months. • Repairs: one per tooth in 12 months. • Supported Prosthetic: one per tooth in 60 months.
Bridges and Dentures	• Dentures and bridgework replacement: one every 5 calendar years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Dentures	• Rebases/Relines: one in 36 months. • Adjustments: one in 12 months.
Crowns/Inlays/Onlays	• Replacement: one every 5 calendar years per tooth.
Tissue Conditioning	• One in 36 months.
Occlusal Adjustments	• One in 12 months.
Type D - Orthodontia	**How Many/How Often**
	• You, Your Spouse, and Your Children, up to age 26, are covered while Dental Insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.

Common Questions… Important Answers

Who is a participating dentist? A participating dentist is a PDP Plus network general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan members. Negotiated fees typically range from 15-45% below the average fees charged in a dentist's community for the same or substantially similar services.*

* Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

How do I find a participating dentist? There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or by calling 1-855-700-7993 (Option 1) to have a list faxed or mailed to you on or after your effective date.

What services are covered by my plan? All services defined under your group dental benefits plan are covered.

Does the Preferred Dentist Program offer any discounts on non-covered services? Negotiated fees may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If permitted, you may only be responsible for the negotiated fee.
* Negotiated fees are subject to change.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He or she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

Can my dentist apply for participation in the network? Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.* The website and phone number are for use by dental professionals only.

* Due to contractual requirements, MetLife is prevented from soliciting certain providers.

How are claims processed? Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-855-700-7993 (Option 1) on or after your effective date.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart from the benefits provided by MetLife.
** Refer to your dental benefits plan summary for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-855-700-7993 (Option 1) and using the MetLife Dental Automated Information Service on or after your effective date. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99-TRUST (7/10)) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 90 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

Metropolitan Life Insurance Company, New York, NY 10166

L0115408342[exp0416][All States][DC,GU,MP,PR,VI]
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Dergalis ASSOCIATES

ADMINISTRATIVE USE ONLY

EFFECTIVE DATE _____ SELLING AGENT _____

Dental and Vision Insurance Enrollment Form

COMPANY NAME **BHHS FOX & ROACH** OFFICE LOCATION _____

NAME _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

SS # _____ BIRTH DATE _____ GENDER ❑ **M** ❑ **F**

EMAIL _____ PHONE _____ HIRE DATE _____

A. PLEASE CHECK ALL COVERAGE(S) YOU ARE APPLYING FOR

❑ METLIFE DENTAL (❍ Basic ❍ Comprehensive ❍ Freedom) ❑ DAVIS VISION

B. PLEASE INDICATE WHO WILL BE INSURED UNDER THE POLICY (CHECK ONLY ONE)

❑ Applying for single coverage for myself ❑ Applying for myself and dependents listed below

C. ENROLLMENT INFORMATION (COMPLETE IF INCLUDING COVERAGE FOR DEPENDENTS)

SPOUSE
Coverage for:
❑ Dental
❑ Vision
❑ Both

NAME _____
SS# _____ BIRTH DATE _____ GENDER ❑ **M** ❑ **F**

CHILD 1
Coverage for:
❑ Dental
❑ Vision
❑ Both

NAME _____
SS# _____ BIRTH DATE _____ GENDER ❑ **M** ❑ **F**

CHILD 2
Coverage for:
❑ Dental
❑ Vision
❑ Both

NAME _____
SS# _____ BIRTH DATE _____ GENDER ❑ **M** ❑ **F**

CHILD 3
Coverage for:
❑ Dental
❑ Vision
❑ Both

NAME _____
SS# _____ BIRTH DATE _____ GENDER ❑ **M** ❑ **F**

SIGNATURE REQUIRED

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

PLEASE READ CAREFULLY. BY SIGNING BELOW, YOU AGREE TO HAVING READ AND UNDERSTOOD THE FOLLOWING:

I hereby authorize **Realty Benefit Services**, **an affiliate of Dergalis Associates**, to access my account 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. I understand there is no monthly paper billing from **Realty Benefit Services**, **an affiliate of Dergalis Associates** and I cannot pay by check.

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. **(You can email your notice to Dergalis Associates at to insurance@agentbenefits.net.)**

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 or become a referral realtor with my current Real Estate firm. This notification is my responsibility. 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.

By signing, I acknowledge that I have read and accept the terms of the above notification agreement.

WERE YOU HELPED BY A DERGALIS REPRESENTATIVE? (please check) ☐ YES ☐ NO

IF YES, WHO: _____

NAME OF INSURED _____

REALTY COMPANY _____ OFFICE LOCATION _____

SOCIAL SECURITY # _____ EMAIL _____

HOME PHONE _____ CELL PHONE _____

HOME ADDRESS _____

CITY *STATE* *ZIP*

SIGNATURE REQUIRED

SIGNATURE *of insured* _____ DATE _____

Co-Signature is required if the insured is not listed on the checking account .

SIGNATURE *of account owner** _____ DATE _____

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

Revised 8/18/2017

Dergalis ASSOCIATES

Attach Voided Check

Attach Your Business Card