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) Email your application with the Automatic Deduction Agreement and the voided check to insurance@agentbenefits.net. 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
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.
Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com and enter client code 4937 or call 1.888-790-9910 to locate providers or for additional information.

Your Davis Vision Designer Plan Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Frequency</th>
<th>In-network Copay</th>
<th>In-network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
<td>Every 12 months</td>
<td>$10</td>
<td>After copay, covered in full. Includes dilation when professionally indicated.</td>
</tr>
<tr>
<td>Spectacle Lenses</td>
<td>Every 12 months</td>
<td>$25</td>
<td>After copay, clear glass or plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. (See below for additional lens options and coatings.)</td>
</tr>
<tr>
<td>Frame</td>
<td>Every 24 months</td>
<td>$0</td>
<td>Covered in Full Frames: Any Fashion or Designer level frame from Davis Vision’s Collection® (retail value, up to $160).</td>
</tr>
<tr>
<td>OR, Frame Allowance</td>
<td></td>
<td></td>
<td>OR, Frame Allowance: $130 toward any frame from provider plus 20% off any balance.</td>
</tr>
<tr>
<td>OR, Contact Lens Allowance</td>
<td></td>
<td></td>
<td>Davis Vision Collection/2 (retail value, up to $160).</td>
</tr>
<tr>
<td>Contact Lens (in lieu of eyeglasses)</td>
<td>Every 12 months</td>
<td>$0</td>
<td>Covered in full with prior approval.</td>
</tr>
<tr>
<td>OR, Medically Necessary Contacts</td>
<td></td>
<td></td>
<td>*Number of contact lens boxes may vary based on manufacturer’s packaging.</td>
</tr>
<tr>
<td>Covering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant savings on optional frames, lens types and coatings!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Davis Vision Collection Frames: Premier</td>
<td></td>
<td></td>
<td>$25</td>
</tr>
<tr>
<td>Tinting of Plastic Lenses or Glass Grey #3 Lenses</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Oversize Lenses</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Scratch Resistant Coating</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Ultraviolet Coating</td>
<td></td>
<td></td>
<td>$12</td>
</tr>
<tr>
<td>Anti-Reflective Coating: Standard</td>
<td>Premium</td>
<td>Ultra</td>
<td>$35</td>
</tr>
<tr>
<td>Polycarbonate Lenses</td>
<td></td>
<td></td>
<td>$0*-$30</td>
</tr>
<tr>
<td>High-index Lenses</td>
<td></td>
<td></td>
<td>$55</td>
</tr>
<tr>
<td>Progressive Lenses: Standard</td>
<td>Premium</td>
<td>Ultra</td>
<td>$50</td>
</tr>
<tr>
<td>Polarized Lenses</td>
<td></td>
<td></td>
<td>$75</td>
</tr>
<tr>
<td>Photochromic Lenses (i.e. Transitions®, etc.): Plastic</td>
<td>Glass</td>
<td></td>
<td>$65</td>
</tr>
<tr>
<td>Intermediate Lenses</td>
<td></td>
<td></td>
<td>$30</td>
</tr>
<tr>
<td>Blended Segment Lenses</td>
<td></td>
<td></td>
<td>$20</td>
</tr>
<tr>
<td>Scratch Protection Plan: Single Vision Lenses</td>
<td></td>
<td></td>
<td>$20</td>
</tr>
<tr>
<td>Scratch Protection Plan: Multifocal Lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Monthly Rates Effective until 4/1/2017-4/30/2022

| Agent       | $7.02 | Agent/Spouse | $12.50 | Agent/Children | $19.43 | Agent/Family | $19.43 |

Using your benefits is easy! Just log on to our Member site at davisvision.com and click “Find a Provider,” or call us at 1.888.790.9910.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through Davis Vision Direct. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!
Frequently Asked Questions

How can I contact Member Services?
Call 1.888.790.9910 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?
Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?
Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?
Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?
You may split your benefits by receiving your eye examination, spectacle lenses and a frame or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?
Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - $40 | single vision lenses - $40 | bifocal/progressive - $60 | trifocal - $80 | lenticular - $100 | frame - $50 | elective contacts - $105 | medically necessary contacts - $225.

Are there any exclusions to the vision benefits?
Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty  Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings  At most participating network locations, members receive up to 20% off additional eyeglasses, sunglasses and items not covered by the benefit and 10% off disposable contact lenses.\(^5\)

Mail Order Contact Lenses  Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction  Up to 25% discount off participating provider’s U&C or 5% off advertised special (whichever is lower). Log on to our member Web site for details and to locate a provider.

Low Vision Services  Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness  Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities, or more information about Davis Vision, please log on to our member Web site or contact us at 1.888.790.9910.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization’s contract with Davis Vision, the terms of the contract will prevail.

Additional discounts not applicable at Walmart, Sam’s Club or Costco locations.

Fully insured plan Underwritten by HM Life Insurance Company of New York. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.
Dental and Vision Insurance Enrollment Form

COMPANY NAME  Coldwell Banker Bain  OFFICE LOCATION

FIRST  MI  LAST  OCCUPATION  Realtor

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

DENTAL  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

FIRST  MI  LAST NAME  GENDER  M  F

SS#  BIRTH DATE  GENDER  M  F

DEPENDENT RELATIONSHIP TO EMPLOYEE

CHILD 1
Coverage for:
- Dental
- Vision
- Both

FIRST  MI  LAST NAME  GENDER  M  F

SS#  BIRTH DATE  GENDER  M  F

DEPENDENT RELATIONSHIP TO EMPLOYEE

CHILD 2
Coverage for:
- Dental
- Vision
- Both

FIRST  MI  LAST NAME  GENDER  M  F

SS#  BIRTH DATE  GENDER  M  F

DEPENDENT RELATIONSHIP TO EMPLOYEE

CHILD 3
Coverage for:
- Dental
- Vision
- Both

FIRST  MI  LAST NAME  GENDER  M  F

SS#  BIRTH DATE  GENDER  M  F

DEPENDENT RELATIONSHIP TO EMPLOYEE

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 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 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

SOCIAL SECURITY #

HOME PHONE

HOME ADDRESS

OFFICE LOCATION

EMAIL

CELL PHONE

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
Attach Voided Check

Attach Your Business Card