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) 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

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.

Lincoln Financial Group®

Full-Time Sales Associates of Florida Realty

Benefits At-A-Glance

Voluntary Short Term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 26 weeks due to injury, illness, surgery, or recovery from childbirth
- Provides a partial cash benefit if you can only do part of your job or work part time
- Features group rates for Florida Realty Sales Associates
- Offers a fast, no-hassle claims process

Short-term Disability	
Weekly benefit amount	Up to 60% of your weekly salary ($100 minimum, $500 maximum) per week, in a $100 increment
Sickness elimination period	30 days
Accident elimination period	30 days
Maximum coverage period	26 weeks

Sickness Elimination Period

- You must be out of work for 30 days due to an illness before you can collect disability benefits. You can begin collecting benefits on day 31.

Accident Elimination Period

- You must be out of work for 30 days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day 31.

Pre-existing Condition

- If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 12 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

No Benefits Reduction

- Your short-term disability benefits can coordinate with income from other sources, such as any state disability benefits, continued income or sick pay from your employer, or Workers' Compensation, during your disability—your benefit will not be reduced by this other income.

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- You are not under the regular care of a doctor when you request disability benefits

A complete list of benefit exclusions and reductions is included in the policy. State restrictions may apply to this plan.

Lincoln Financial Group®

All Full-Time Employees of Florida Realty

Benefits At-A-Glance

Voluntary Long Term Disability Insurance

The Lincoln Long-term Disability Insurance Advantage Plan:

- Provides a cash benefit after you are out of work for 180 days or more due to injury, illness, or surgery
- Features group rates for Florida Realty employees
- Includes *EmployeeConnect*SM services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance

Long-term Disability	
Monthly benefit amount	60% of your monthly salary, limited to $5,000 per month
Elimination period	180 days
Coverage period for your occupation	24 months
Maximum coverage period	2 years or up to age 70, whichever comes first

Elimination Period

- This is the number of days you must be disabled before you can collect disability benefits.
- The 180-day elimination period can be met through either total disability (out of work entirely) or partial disability (working with a reduced schedule or performing different types of duties).

Coverage Period for Your Occupation

- This is the coverage period for the trade or profession in which you were employed at the time of your disability (also known as your own occupation).
- You may be eligible to continue receiving benefits if your disability prohibits you from any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits are extended through the end of your maximum coverage period (benefit duration).

Maximum Coverage Period

- This is the total amount of time you can collect disability benefits (also known as the benefit duration).

Pre-existing Condition

- If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 12 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 24 months, unless you received no treatment of the condition for 12 consecutive months after your effective date.

Additional Plan Benefits

Open Enrollment

- When you are first offered this coverage (and during approved open enrollment periods), you can take advantage of this important coverage.
- If you decline this coverage now and wish to enroll later, a health examination may be required.

Benefit Exclusions & Reductions

Like any insurance, this long-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- You are not under the regular care of a doctor when you request disability benefits
- Your disability occurs while you are committing a felony or participating in a riot
- Your disability occurs while you are imprisoned for committing a felony
- Your disability occurs while you are residing outside of the United States or Canada for more than 12 consecutive months for a purpose other than work

Your benefits may be reduced if you are eligible to receive benefits from:

- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation
- Salary continuance
- Sick leave

A complete list of benefit exclusions and reductions is included in the policy. State restrictions may apply to this plan.

Lincoln Financial Group®

HomeServices of America

Benefits At-A-Glance

Voluntary Term Life Insurance

The Lincoln Term Life Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Features group rates for Ambassador Real Estate employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Newly hired employee guaranteed coverage amount	$150,000
Maximum coverage amount	$500,000 maximum in increments of $5,000
Minimum coverage amount	$5,000
Spouse	
Newly hired employee guaranteed coverage amount	$25,000
Maximum coverage amount	$250,000
Minimum coverage amount	$2,500
Dependent Children	
6 months to age 19 (to age 25 if full-time student) guaranteed coverage amount	$10,000
Age 14 days to 6 months guaranteed coverage amount	$250

What your benefits cover

Employee Coverage

Guaranteed Life Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $150,000 without providing evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to $500,000 with evidence of insurability. See the Evidence of Insurability page for details.
- The maximum coverage amount for employees 70 and older who are electing coverage for the first time is $50,000.
- Your coverage amount will reduce by 35% when you reach age 65; an additional 15% of the original amount when you reach age 70; and an additional 20% of the original amount when you reach age 75.

Spouse Coverage - You can secure term life insurance for your spouse if you select coverage for yourself.

Guaranteed Life Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $25,000 maximum for your spouse without providing evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to ($250,000 maximum) for your spouse with evidence of insurability.
- Coverage amounts are reduced by 35% when an employee reaches age 65.

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: $5,000 and $10,000.

Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included

Benefit Exclusions

Like any insurance, this term life insurance policy does have exclusions. A suicide exclusion may apply. A complete list of benefit exclusions is included in the policy. State variations apply.

Questions? Call 800-423-2765.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. *TravelConnect*® travel assistance services are provided by On Call International, Salem NH. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. ComPsych® and On Call International are not Lincoln Financial Group companies and Lincoln Financial Group does not administer these Services. Each independent company is solely responsible for its own obligations. Coverage is subject to contract language that contains specific terms, conditions, and limitations.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.

Lincoln Financial Group®

Florida Realty
Group Insurance Rates

Lincoln Dental

Monthly Rates*	
Agent	$48.90
Agent/Spouse	$110.18
Agent/Child	$116.05
Agent/Children	$116.05
Family	$142.43
Effective 3/1/2020 to 4/30/2021	

Davis Vision

Monthly Rates*	
Agent	$7.89
Agent/Spouse	$15.77
Agent/Child	$15.77
Agent/Children	$23.66
Family	$23.66
Effective 3/1/2020 to 4/30/2022	

Lincoln Financial Group Life Insurance

Monthly Rates*	
$150,000 Benefit Amount	
Age	Rate
<30	$11.13
30-34	$14.31
35-39	$19.08
40-44	$27.03
45-49	$46.11
50-54	$79.50
55-59	$119.25
Dependent Child Life $5,000	$1.06
Amounts over $150,000	
Require Evidence of Insurability Paperwork	
Are subject to underwriting requirements and you may be denied.	
Spousal rates are based on the agent's date of birth.	

Lincoln Financial Group Short-Term Disability

Monthly Rates Per*	
$500 Weekly Benefit Amount	
Age	Rate
0-29	$19.08
30-34	$18.02
35-39	$16.43
40-44	$16.43
45-49	$18.02
50-54	$19.61
55-59	$23.32
60-64	$27.56
65-69	$31.27
70-74	$34.45
75-99	$37.63

Lincoln Financial Group Life Insurance Over Age 60

Monthly Rates*	
$10,000 Guarantee Issue Amount	
Age	Rates
60-64[1]	$12.19
Monthly Rates*	
$6,500 Guarantee Issue Amount	
65-69[2]	$15.50
Amounts over $10,000	
Require Evidence of Insurability Paperwork	
Are subject to underwriting requirements and you may be denied.	
Spousal rates are based on the agent's date of birth	
[1]Max benefit of $490,000 [2]Max benefit of $315,000	

Lincoln Financial Group Long-Term Disability

Monthly Rates Per*	
$1000 Monthly Benefit Amount	
Age	Rate
<30	$2.86
30-34	$3.71
35-39	$4.66
40-44	$5.72
45-49	$10.39
50-54	$15.26
55-59	$26.71
60-64	$39.43
65-69	$41.34
70-74	$24.70
75-99	$26.61

***These rates include a 6% administrative fee.**

****These rates include a 4% administrative fee.**
These rates are for illustrative purposes and are subject to change without notice. For more specific information refer to the highlight sheets.

Revised 7/8/2020

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: 800-423-2765 Fax: 877-573-6177

Here is your Enrollment Form.

Follow these steps to complete the form.
Print clearly in ink.
Step 1: Fill in or confirm your personal information.
Step 2: Fill in dependent information, if any.
Step 3: Select your benefits.
Step 4: Assign beneficiaries.
Step 5: Confirm enrollment.
Step 6: Sign, date & return the form.

Group ID:_____

1. Your Personal Information

Group/Employer/Participating Organization Name | County | Zip | State
Florida Realty

Your First Name | Middle Name/MI | Last Name | Social Security No. | Employee ID No. | Date of Birth

Street Address (Include Apt. or Suite No.) | City | State | Zip

Home Phone | Cell Phone | Work Phone | Email Address

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

2. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ **Spouse**

First Name | Middle Name/MI | Last Name | Social Security No. | Date of Birth

Provide contact information if different than Your information above.

Home Phone | Cell Phone | Work Phone | Email Address

Dependent Children – List all children you are enrolling (attach a separate sheet, if needed).

First Name	Middle Name/MI	Last Name	SSN (Optional)	Gender	DOB	Full-time Student
				☐ Male ☐ Female		☐ Yes ☐ No
				☐ Male ☐ Female		☐ Yes ☐ No
				☐ Male ☐ Female		☐ Yes ☐ No

Employer Completes this Section.

Billing Division or Location: _____
Sort Group/Code: _____ Payroll Cycle: _____
Policy #(s): _____
Average Hours Worked Per Week: _____ ☐ Full-time ☐ Part-time Occupation: _____
Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $_____ Date of Employment: ___/___/___
Actively at Work? ☐ Yes ☐ No Date of Rehire: ___/___/___

Continue on Next Page. . .

3. Benefit Selection — Choose your benefits.

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate.

Basic Group Insurance

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium
Class	Effective Date			
_____	_____/_____/_____	Dental ☐ Yes ☐ No *By selecting No, you may be subject to late entrant or benefit waiting periods on certain services if you enroll at a later date.*	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/ Children	$_____

Voluntary/Optional Group Insurance

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions as stated in the policy and certificate.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium
Class	Effective Date			
_____	_____/_____/_____	Voluntary Life Only ☐ Yes ☐ No*	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Spouse Only) Life Only ☐ Yes ☐ No* *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Child Only) Life Only ☐ Yes ☐ No* *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	_____/_____/_____	Voluntary Short Term Disability (STD) ☐ Yes ☐ No*	Weekly Benefit Amount: $_____	$_____
_____	_____/_____/_____	Voluntary Long Term Disability (LTD) ☐ Yes ☐ No*	Monthly Benefit Amount: $_____	$_____

*By selecting "No," application for insurance at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

3. Benefit Selection — Continued. Complete if you are enrolling for Dental insurance.

Are you or any of your eligible dependents covered by another dental plan? ☐ Yes (If Yes, please list) ☐ No

Name of Insured	Insurance Company Name, Phone and Policy No.	Employer

4. Select Your Beneficiaries — Choose who receives your insurance benefits.

Primary Beneficiary(ies)
The Primary Beneficiary is the person(s) you identify to receive insurance benefits upon your death.

If more than three Primary Beneficiaries, please attach a separate sheet of paper.
If multiple Primary Beneficiaries, total percentage of all combined must equal 100%.

First Name _____ Middle Initial _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number ___-___-___ Date of Birth ___/___/___ Relationship to You _____ Percentage _____% Phone Number (___) ___-___

First Name _____ Middle Initial _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number ___-___-___ Date of Birth ___/___/___ Relationship to You _____ Percentage _____% Phone Number (___) ___-___

First Name _____ Middle Initial _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number ___-___-___ Date of Birth ___/___/___ Relationship to You _____ Percentage _____% Phone Number (___) ___-___

Contingent Beneficiary(ies) and Other Beneficiary Designations

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive you. Please attach a separate sheet to identify a Contingent Beneficiary. If multiple Contingent Beneficiaries, total percentage of all combined must equal 100%. To name a Beneficiary(ies) by product, attach a separate sheet identifying product and beneficiary.

Continue on Next Page. . .

5. Confirm Enrollment

This group insurance has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **ENROLL FOR INSURANCE for which I am or may become eligible** under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.

☐ **NOT ENROLL myself in the group insurance offered.** I understand if I enroll for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

☐ **NOT ENROLL my dependents in the group insurance offered.** I understand if I enroll my dependents for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

Fraud Warning/State Disclosure(s)

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

6. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): _____

Your Signature: X_____ **Date** _____/_____/_____

Complete and return this form.

(Be sure to sign and date the form to start your insurance.)

Questions? Call 800-423-2765

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 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