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.

DAVIS VISION
EYECARE REFRAMED℠

Designer Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations and eyeglasses!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Log on to Davisvision.com. Click on Member/Open Enrollment, then enter Client Code 4196. Click "Find a Provider" to locate a provider near you including:

Visionworks

IN-NETWORK BENEFITS	
Eye Examination	Every 12 months, **Covered in full**
Eyeglasses	
Spectacle Lenses	Every 12 months, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses
Frames	Every 12 months, **Covered in full** Any Fashion frame from Davis Vision's Collection[1] (value up to $100) OR $60 retail allowance toward any frame from provider.
Contact Lenses	
Contact Lenses (in lieu of eyeglasses)	Every 12 months $75 retail allowance toward provider supplied contact lenses.

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$25	$0
Polycarbonate Lenses	$66	$0[2]-$35
Standard Anti-Reflective (AR) Coating	$83	$40
Standard Progressives (no-line bifocal)	$198	$65
Plastic Photosensitive lenses[3]	$110	$70

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Eye Examination	$103	$0
Lenses		
Bifocals	$116	$0
Scratch-Resistant Coating	$25	$0
Transitions®[3]	$110	$70
Frame	$160	$0
Total	$514	$70

Savings up to:
$444

Member contribution rates good through April 30, 2022	Monthly	Annually
Member	$7.89	$94.68
Member plus Spouse	$15.77	$189.24
Member plus Child	$15.77	$189.24
Member plus Children	$23.66	$283.92
Member plus Family	$23.66	$283.92

For more Details.....

The Group Insurance Department
P: (888) 564-0300
F: (856) 396-3193
E: insurance@agentbenefits.net

[1] The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change.
[2] For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
[3] Transitions® is a registered trademark of Transitions Optical Inc.

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

OE00883 2/11/15

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through 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 discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
FRAMES		
Fashion Frame (from the Davis Vision Collection)	$100	$0
Designer Frame (from the Davis Vision Collection)	$160	$20
Premier Frame (from the Davis Vision Collection)	$195	$40
LENSES		
All Ranges of Prescriptions and Sizes	**$90**	**$0**
Plastic Lenses	**$78**	**$0**
Oversized Lenses	**$20**	**$0**
Scratch-Resistant Coating	**$25**	**$0**
Tinting of Plastic Lenses	$25	$15
Polycarbonate Lenses	$66	$0[1/] or $35
Ultraviolet Coating	$25	$15
Standard Anti-Reflective (AR) Coating	$83	$40
Premium AR Coating	$104	$55
Standard Progressive Addition Lenses	$198	$65
Premium Progressives Addition Lenses	$247	$105
Ultra Progressive Addition Lenses	$369	$140
High-Index Lenses	$120	$60
Polarized Lenses	$103	$75
Plastic Photosensitive Lenses (i.e.Transitions®, etc.)[2/]	$110	$70
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

[1/] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

[2/] Transitions® is a registered trademark of Transitions Optical, Inc.

Out-of-Network 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 request a claim form for reimbursement from:

Group Insurance
Dergalis Associates

1-888-564-0300
insurance@agentbenefits.net

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $32 | Frame up to $30 Spectacle Lenses (per pair) up to: Single Vision $25, Bifocal $36, Trifocal $46, Lenticular $72 Daily wear fitting and evaluation up to $20, Extended wear fitting and evaluation up to $30 Elective Contacts up to $75, Medically Necessary Contacts up to $225

Dergalis ASSOCIATES

ADMINISTRATIVE USE ONLY

EFFECTIVE DATE

Dental and Vision Insurance Enrollment Form

COMPANY NAME _____ OFFICE LOCATION _____

NAME _____ OCCUPATION _____

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

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**

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 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.

SIGNATURE *of insured* _____ DATE _____

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 *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 11/06/2019

Dergalis ASSOCIATES

Attach Voided Check or Savings Deposit Slip

Attach Your Business Card