

**REAL ESTATE ONE  
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. (Dergalis Associates FAX: (856) 396-3193 Att: Claire Juliano)

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 \_\_\_\_\_

\*Please retain a copy of this document in your file with your application(s).

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**