



Flexible Benefits Plans

www.flexiben.com

# APPLICATION FOR MEMBERSHIP

Please enroll us in the FBP BUSINESS SERVICES ASSOCIATION effective \_\_\_\_/\_\_\_\_/\_\_\_\_.

Name of Firm: \_\_\_\_\_

Address: \_\_\_\_\_  
(Flexible Benefits Plans, Inc. does not accept PO Boxes as a valid address)

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Number of Employees: Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

**COST CALCULATION** – If you are going to participate in an Association-sponsored insurance plan, use the worksheet below to determine your total monthly payments.

List name and cost for each employee to be covered (use separate sheet of paper if necessary).

_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

Subtotal: \$ \_\_\_\_\_

Billing Fee: \$ \$10.00

Monthly Total: \$ \_\_\_\_\_

\*\*PLEASE MAKE CHECKS PAYABLE TO: FLEXIBLE BENEFIT PLANS

**TOTAL INITIAL PAYMENT:** \$ \_\_\_\_\_

I understand that employees will be eligible for coverage under policies of insurance or other forms of coverage only if they continue to meet the insurer's or provider's eligibility and underwriting guidelines.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Please Print Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Date: \_\_\_\_\_