Flexible Benefits Plans
Powered by FNA

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:_____

Valley Forge Commons East Bldg. 57
1288 Valley Forge Road, P.O. Box 873, Valley Forge, PA 19482
Phone: (610) 482-1800 Fax: (610) 482-1803

3831

UNITED CONCORDIA® Dental Enrollment Form

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please select the applicable "Type of Activity" in Section A and provide the identification number and employee name in Section C (also complete Section D for dependent changes).

Fill in circles completely: ● Correct ⊗ Incorrect

For best results, print in capital letters and avoid contact with edge of box.

Example: A B C

SECTION A: GENERAL INFORMATION

1.

Choice of Plan

- ○ $1500 Basic (259171001)
- ○ $1500 Comprehensive (259170001)
- ○ $2250 Enhanced (259170003)

2. TYPE OF ACTIVITY

- ○ **New Enrollment**
- ○ **Cancel Coverage**
  - ○ Cancel All Coverage (Employee & All Dependents)
  - ○ Cancel Dependent(s) Only (List dependents to be cancelled in Section D)
  - ○ Cancel Spouse Only (List spouse to be cancelled in Section D)
- ○ **Change (Include Group Number in Section B)**
  - ○ Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - ○ Change Address
  - ○ Reinstate Coverage
  - ○ Change Group Number
  - ○ Change Provider
  - ○ Change Name
  - ○ To COBRA Group
  - ○ Other_____

Effective Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

SECTION B: EMPLOYER USE ONLY

Employer Name

Group Number (9 digits)

UCCI Payroll Location

SECTION C: EMPLOYEE INFORMATION—Please print clearly to expedite your request.

Identification Number (Social Security Number) ☐☐☐☐☐☐☐☐☐

Date of Birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Sex ☐

Original Employment Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

First Name

M.I.

Last Name

Home Address

City

State

ZIP Code

SECTION D: DEPENDENT INFORMATION—Please list the added/cancelled dependents in this section. For more than six dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time student age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

Spouse/Domestic Partner

#1 **Identification Number** (Social Security Number) ☐☐☐☐☐☐☐☐☐

Date of Birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Sex ☐

Provider Number (DHMO only)

First Name

M.I.

Last Name

Dependent

#2 **Identification Number** (Social Security Number) ☐☐☐☐☐☐☐☐☐

Date of Birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Sex ☐

Provider Number (DHMO only)

First Name

M.I.

Last Name

#3 **Dependent Identification Number** (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#4 **Dependent Identification Number** (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#5 **Dependent Identification Number** (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#6 **Dependent Identification Number** (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

SECTION E: OTHER DENTAL COVERAGE

—Do you or your dependent(s) have other Group Dental Coverage? Yes ◯ No ◯

If your answer is yes, please complete the following information.

Policyholder Name (First, M.I., Last)	**Insurance Company**
Policy/Identification Number	**Effective Date** (mm/dd/yyyy)

I represent that all information supplied in this 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.

Employee Signature | **Phone Number** | **Email Address** | **Date**

Employer Signature | **Phone Number** | **Date**

Flexible Benefits Plans

Powered by FNA

www.flexiben.com

PRE-AUTHORIZED ACH DEBIT FORM

POLICY NUMBER: _____ (New members should leave this field blank)

Authorization to Honor Debits by Flexible Benefits Plans, Inc.

Please sign the authorization in the designated area in accordance with your signature(s) on file at your financial institution. Please notify us if you change your address or wish us to charge a different account in the future.

I hereby authorize this financial institution to pay and charge my account for electronic debits drawn on my account by Flexible Benefits Plans, Inc. to its own order. This authorization will remain in effect until revoked by me, in writing, and until you receive such notice. I agree that you shall be fully protected in honoring any such electronic debit.

I agree that your treatment of each such electronic debit, and your rights to respect it, shall be the same as if it were signed by me personally. I further agree that if any such electronic debit be dishonored, whether with or without cause, you shall be under no liability **whatsoever even though such dishonor results in the lapse of insurance**.

DEPOSITOR(S)	YOUR BANK
_____	_____
Depositor Name listed on the account	Bank Name
_____	_____
Joint Depositor (if any)	Bank Address
_____	_____
Signature of Depositor	City State Zip Code
_____	_____
Signature of Joint Depositor	Bank Phone
_____	_____
Email Address (Required)	Checking Account Number you wish us to debit

Debits are transacted on the 25th of the month prior. All changes to ACH must be submitted to our office by the 20th of the month in order to guarantee your changes.

*** Please attach a voided check (no deposit slips, please) ***

Valley Forge Commons East Bldg. 57
1288 Valley Forge Road, P.O. Box 873, Valley Forge, PA 19482
Phone: (610) 482-1805 Fax: (610) 482-1803

Flexible Benefits Plans
Powered by FNA

Extranet Registration Form

Broker ID (or) Group Number _____

Name _____

Email Address _____

Address _____

City/State/Zip _____

Primary Contact _____

Monthly Statement Delivery ☐ **Online Only** ☐ **Mailed** **(this is not an option for those enrolled in ACH)**

Once you have completed this form please sign and return it to FBP; attention Systems Development:

- **Email:** noe.fbp.support@fnainsurance.com
- **Fax:** (610) 482-1803
- **Return with your premium payment**

Once we have received your request and process your information we will contact you with your user name and password.

I have read and fully understand the Terms & Conditions of access to the Flexible Benefits Plans, Inc, Extranet.

_____ _____
Signature Date

Valley Forge Commons East, Building 57
1288 Valley Forge Road
P.O. Box 873
Valley Forge, PA 19482-0873

Flexible Benefits Plans, Inc.
Terms and Conditions of Client Extranet Access

Flexible Benefits Plans, Inc. (FBP) provides you with access to the Client Extranet, subject to the following Terms and Conditions ("Terms and Conditions"). We may update the Terms and Conditions at any time and without notice. Unless stated otherwise, changes will be effective when they are posted on our web site at www.flexiben.com. The Terms and Conditions are in addition to those that are posted on our web site at www.flexiben.com under the Legal Information section, which is incorporated herein by reference. By logging onto the Client Extranet, activating your password and creating a User Identification, User ("you") understands and agrees to be bound by these Terms and Conditions.

- Flexible Benefits Plans, Inc. reserves the right to terminate your access to the Client Extranet at any time and for any reason at FBP's sole discretion. Your access will be terminated automatically when your benefits are no longer provided by FBP. FBP reserves the right at any time to modify or discontinue, temporarily or permanently, the Client Extranet (or any part thereof) with or without notice. You agree that FBP will not be liable to User or to any third party for any modification, suspension or discontinuance of the Client Extranet, or termination of your access to the Client Extranet.

- FBP has created certain security procedures, including the use of passwords and user identification numbers, to assist in keeping information on the Client Extranet confidential. You agree to provide us with accurate, current, and complete information about Employer and Employer's members and intermediaries (as that term is defined below), as requested, and to maintain and promptly update said information to keep it accurate, current and complete. You are responsible for maintaining the confidentiality of your password / user identification and are responsible for all activities that occur under your password / user identification. You agree to immediately notify FBP of any unauthorized use of your password or user identification, change in intermediaries, or other breach of security, and to exit from your account at the end of each session. You may report violations of the Terms and Conditions to: (email address). FBP will not be liable for any losses and/or damages arising from your failure to comply with these provisions. Except where expressly authorized by law, you may not use another person's password or user identification to access the Client Extranet, and agree not to misrepresent your affiliation with a person or entity to obtain access to the Client Extranet. You also agree not to copy or disseminate, electronically or otherwise, personal or confidential information found on the Client Extranet. You agree to maintain the confidentiality of all member information provided to you by FBP in accordance with applicable federal, state, and local laws / regulations.

- The information you provide to us is subject to our Privacy Policy, which can be accessed at (website).

- You agree to comply with FBP's policies and procedures regarding access to and use of the Client Extranet, including, FBP's underwriting and enrollment guidelines / requirements. You understand and agree that any request to add, modify or terminate a member is subject to review by FBP. Any transmission requesting an addition, modification or termination is considered a request and is not binding until and unless an FBP representative approves the request. You also agree to retain FBP's standard enrollment form signed by Employer's eligible members and to provide FBP with paper copies of the signed FBP enrollment form. If you use an enrollment form other than FBP's form, Employer's form must state or contain the following provisions: (a) the member's coverage is subject to the terms and conditions of the applicable group benefit contract, which in the case of HMO coverage, provides that except for emergencies, all medical care must be initiated by the primary care

provider selected by the member; (b) the member authorizes FBP to obtain, use and disclose member related health and medical information for benefit administration, claims payment, utilization review, and quality assurance purposes; and (c) Pennsylvania law states: "Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information or conceals for the purposes of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

- **Unless otherwise agreed by the parties in writing, all transactions performed using the Client Extranet for enrollment and billing/premium services shall be deemed to be between the Employer, in its capacity as Plan Sponsor under the Health Insurance Portability and Accountability Act on 1996 and its regulations (HIPAA), and FBP.**

- The Client Extranet, and certain information contained within it, are owned by and proprietary to FBP, and are protected by copyright, trademark and other intellectual property laws.

- The information provided on the Client Extranet is provided as an accommodation and it is not intended to serve as formal notice or publication as may be required under law or by contract. Except as required by law, FBP assumes no responsibility for the timeliness, deletion, mis-delivery or failure to provide any information on the Client Extranet. Your use of the Client Extranet is at your sole risk. **While FBP strives to maintain the accuracy and reliability of the information available through the Client Extranet, FBP cannot guarantee the complete accuracy of any information on the Client Extranet, including rating and enrollment information.** The Client Extranet is provided on an "AS IS" and "AS AVAILABLE" basis. FBP makes no warranty that the site will be uninterrupted, timely, secure or error-free. You assume all risks of downloading data or making transmissions electronically. FBP expressly disclaims all warranties of any kind, whether express or implied, including, but not limited to, the implied warranties of merchantability, fitness for a particular purpose and non-infringement. You understand and agree that FBP will not be liable for any direct, indirect, incidental, special, consequential or exemplary damages for any reason resulting from your use of the Client Extranet, including but not limited to damages related to your use or inability to use this site; and/or unauthorized access to or alterations to your transmissions or data.

- You agree to release and hold FBP, and their directors, officers, agents, principals or other partners, and employees harmless from any claims, demands, losses, damages, liabilities, costs and expenses, including reasonable attorneys' fees, made by any third party due to or arising out of you and/or your employees, agents and intermediaries use of the Client Extranet, violation of these Terms and Conditions, communication of incomplete or inaccurate member information, and / or violation of law. The Terms and Conditions governing access to the Client Extranet will be governed by the laws of the Commonwealth of Pennsylvania.

- Employer may engage a third party administrator , broker or consultant ("intermediary"), subject to FBP's prior written approval of the intermediary designated on the signed Employer Authorization Form, to perform Employer's duties and obligations in accordance with the Terms and Conditions governing use of the Client Extranet. In such an event, Employer agrees to: (a) provide intermediary with a copy of the Terms and Conditions governing the use of the Client Extranet; and (b) be responsible for all acts and / or omissions of the intermediary acting on the Employer's behalf, including any breach of the Terms and Conditions governing the use of the Client Extranet.

The Terms and Conditions constitute the entire agreement between you and FBP and govern your use of this site.