Enroll Today! Dental Insurance for Real Estate Industry Professionals!

RE+HIT
Real Estate Industry
Health Insurance Trust
Plan Sponsor

Choices. You have access to two dental insurance plans – a Delta Dental PPO **OR** if in Washington State a Dental Health Services HMO plan. These plans offer you extensive preventive coverage and can protect you and your family from unexpected dental expenses. **Open enrollment ends June 30th so get your application in today!**

DELTA DENTAL
Washington Dental Service

Option 1:
Your dental plan offers three classes of covered treatment. Each class provides specific types of treatment and typically covers those treatments at a certain percentage. Class I procedures are typically diagnostic and preventive, and are covered at 100 percent. This encourages patients to seek preventive care. Class II includes basic procedures - such as fillings and extractions - which are covered at 70 percent. Class III is for major procedures - such as crowns and dentures - which are reimbursed at 50 percent.

Dental Health Services

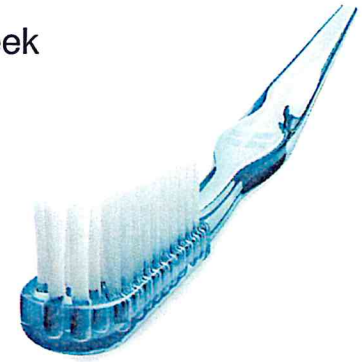
Option 2:
Your dental plan allows you and your family to receive service from a network of local, independently owned, quality assured dental offices. Using the plan is easy. Simply select a conveniently located participating dentist, who will then assess your oral health and outline an appropriate treatment plan. Your care then proceeds according to this plan. Most procedures require you to pay a copayment, as listed in the Schedule of Covered Services and Copayments brochure.

Open Enrollment:

- Now is the time to enroll in your choice of two dental plans available to Real Estate Agents and employees
- Enrollment must be received prior to June 30th

To Qualify You Must:

- Be an active licensed Agent
  OR
- Be a W-2 employee and work more than 20 hours per week



To Learn More or Enroll:

- Email: benefits@bcnw.com
- Call: **(800) 945-4193**

Submit Enrollment Materials by:

- Fax: **(800) 861-3395**
- Email: benefits@bcnw.com
- Mail: Benefit Consultants Northwest
  Bain Building, Suite 108
  1717 W. Francis Avenue
  Spokane, WA 99205

BCNW
Benefit Consultants Northwest
Plan Administrator

RE+HIT
Real Estate Industry
Health Insurance Trust
Plan Sponsor

ENROLL TODAY!
Dental Insurance for Real Estate Industry Professionals! (800) 945-4193

July 1 2017– June 30th 2018
Dental Options

DELTA DENTAL
Washington Dental Service

Dental Health Services

	Delta Dental (WDS) Plan (PPO/Premier Networks)	Dental Health Services Prepaid HMO (WA state ONLY)
Basic Package	Option 1	Option 2
Class I (Preventive)	100% (80% non-PPO)	100% after Copays
Class II (Basic)	70% (60% non-PPO)	100% after Copays
Class III (Major)	50% (40% non-PPO)	100% after Copays
Deductible	$50	None
Waived for Class I?	Yes	N/A
Annual Max Benefit	$1,500	No Limit
Orthodontia	No	Yes ($3,395 copay)
Waiting Periods		
Class I	None	None
Class II	None	None
Class III	12 mos.	None
Orthodontia	N/A	None
Service Categories		
Oral Surgery	Class II	Class III
Periodontics	Class II	Class III
Endodontics	Class II	Class III
Rates		
Subscriber Only	$53.25	$26.94
Subscriber + Spouse	$105.16	$49.88
Subscriber + Child(ren)	$113.51	$65.10**
Family	$165.42	$83.30***
Access		
Dentists	Delta Dental Dentists	DHS HMO Dentists
Area	Any State	WA Only
Websites	www.deltadental.com	www.dentalhealthservices.com

* Dental HMO plans do not have specific Class I, II and III benefits. This class was assigned based on the level of copays charged for these services.

** Rate for member + 2 dependents
*** Rate for member + 3 or more dependents

Benefit Consultants Northwest is the plan administrator of the Real Estate Health Insurance Trust.

BCNW
Benefit Consultants Northwest
Bain Building, Suite 108
1717 W. Francis Avenue
Spokane, WA 99205
Plan Administrator

RE+HIT
Real Estate Industry
Health Insurance Trust

REHIT Dental Enrollment Packet

For help with enrollment or questions call: (800) 945-4193

1. Confirm Qualification for Eligibility into the Insurance Program

Eligibility Requirement Verification- Mark Appropriate Box Below:

☐ Self Employed Agents- I am currently a self employed agent with an active license.
*Please provide copy of most current business card.

☐ W-2 Employees- I am a W-2 employee in the Real Estate Industry, who is employed 20 or more hours per week. My employer is located at the following office:
Office Name_____
Office Address_____

☐ I am a W-2 employee who is NOT employed 20 or more hours per week. STOP! You are not eligible to enroll at this time.

Failure to meet Eligibility Requirements

The Participating Party's coverage under this agreement may be terminated if such party no longer meets the requirements established by the Group.

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

2. Complete the Option 1- Delta Dental OR Option 2- Dental Health Services enrollment form

➢ Forms are attached to back page of this Enrollment Packet

3. Premium Payment Options

There are three ways to pay for your monthly premiums depending on your Agent or Employee status. Please designate the payment option you will be utilizing by the box next to your choice.

1. W-2 employees whose premiums are paid by their employer are expected to be billed as part of an office group on a monthly basis. There will be no requirement for establishing or maintaining a reserve premium for employer paid groups.

☐ I am a W-2 employee whose employer will be paying my premium.
Please bill my employer at address provided above.

REHIT Dental Enrollment Packet

2. Agents can choose to be billed on a monthly basis by an electronic statement.
Those agents who elect to use this method are required to establish and maintain a reserve account equal to one month's premium.

☐ I am an agent and I choose to be billed monthly by an electronic statement at the following Email address: _____

NOTE: Please send two month's premium with your application form. One will pay for your first month of coverage. The other will establish your required reserve premium account. Make Check Payable to "BCNW"

3. Agents can choose to set up an automatic premium payment plan through their bank.
Paying by automatic bank draft also removes you from the requirement to establish and maintain a one month reserve premium and please note the monthly premiums are discounted on this method.

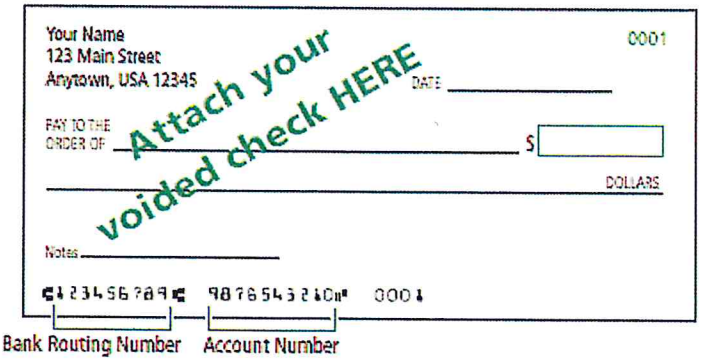
☐ I am an agent and I choose to set up an automatic premium payment (please complete Bank Draft Authorization Section below) :

Bank Draft Authorization

Applicants Name _____

Address _____ Telephone _____

Attach your voided check below



I (we) hereby authorize Benefit Consultants Northwest to initiate debit entries to my (our) checking account and the Financial Institution named above to debit the same to such account. BCNW will not be held accountable for a policy lapse or cancellation due to non-payment if the withdrawal is presented and not honored for any reason and the amount due is not paid.

This authority is to remain in full force and effective until BCNW and the Financial Institution have received written notification from me (either of us) of its termination in such time and in such manner as to afford BCNW and the Financial Institution a reasonable opportunity to act upon it.

Printed Name _____ **Date** _____

Signature _____

Be sure to attach a voided check to this form.
Your insurance premium(s) will be drafted on the 25th of each month.

Return completed forms to Benefit Consultants Northwest, Inc, Plan Administrator at contact information below:

Email: benefits@bcnw.com

Postal Mail:
Benefit Consultants Northwest
Attn: REHIT Dental plan
1717 W. Francis Avenue, Suite 108
Spokane, WA 99205

Fax:
(800) 861-3395

DELTA DENTAL

Delta Dental of Washington

PO Box 75688 | Seattle WA 98175-0688
(206) 528-5335 or (800) 572-7835 x 5335

Enrollment Form

DDWA Small Business Plans

☐ New ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Reinstate ☐ Other (Check One)

Employer or Group Name	Group Number	Subgroup	Hire Date	Effective Date	
REHIT	978			07/01/2017	
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Address		City	State	Zip	
Phone Number		Email Address			

Dependents

Please list all dependents to be covered:

First Name	Middle Initial	Last Name	Birthdate	Gender	Add/ Remove	Dependent Over Limiting Age Verification*
Spouse or Domestic Partner**				M ☐ F ☐	Add ☐ Remove ☐	
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐

Coordination of Benefits

Do any of your dependents have other dental coverage? Yes ☐ No ☐ If yes, please complete the section below.

Employer Group Number and Name			Effective Date		
Name and Address of Other Insurance Carrier					
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender

COBRA Enrollment Only

Indicate Qualifying Date
Indicate Qualifying Event ☐ Termination ☐ Reduction in Hours ☐ Divorce ☐ Widowed/Surviving Dependent ☐ Dependent Child No Longer Eligible ☐ Other

Continued on back ▸▸

Waiver Dental Coverage

I certify that I have been advised of the features and benefits of the dental plan offered to me through my employer and after due consideration, I have chosen:

- ☐ Not to enroll my spouse in the group dental plan being offered by my employer.
- ☐ Not to enroll my children in the group dental plan being offered by my employer
- ☐ Not to enroll myself and my dependents in the group dental plan being offered by my employer. I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits (R.C.W. 48.135.080).

* The minimum limiting age is through age 25 for all children; coverage shall not terminate for children over the age of 25 who are both (1) incapable of self-sustaining employment by reason of developmental disability or physical handicap and (2) chiefly dependent upon the employee or member for support and maintenance

** Domestic partners include state-registered partnerships and/or other domestic partners if specifically covered by group.

*** Documentation is required (pursuant to R.C.W. 48.44.210). To download the proof of incapacity and dependency form, visit the Delta Dental of Washington website at www.DeltaDentalWA.com/forms.

Signature _____ Date _____

Dental Health Services

Enroll today!

You are now eligible for membership in a Dental Health Services dental plan. You and your family now have an affordable, quality alternative to high dental costs and traditional dental insurance. We look forward to the opportunity to serve you!

How does my plan work?

Your dental plan allows you and your family to receive service from a network of local, independently owned, Quality Assured dental offices. Using the plan is easy. Simply select a conveniently located participating dentist, who will then assess your oral health and outline an appropriate treatment plan. Your care then proceeds according to this plan. Most procedures require you to pay a copayment, as listed in the enclosed Schedule of Covered Services and Copayments brochure.

What is a copayment?

A copayment is the amount listed in the Schedule of Covered Services and Copayments that you pay directly to your participating dentist at the time you receive care.

How do I receive dental care?

As soon as you are enrolled and your plan has become effective, simply telephone your selected dental office and ask for an appointment time that works best for you. Your participating dentist receives an updated membership list every month, so it is not necessary to have your membership card to make an appointment or to receive care.

How do I select a dentist?

Simply note the dentist number for the participating dentist you would like to receive care from on your enrollment form. You may change dentists at any time by contacting your Member Service Specialist.

What if I have a dental emergency on the weekend, after office hours, or when I am out of town?

Participating dentists are expected to maintain 24-hour emergency availability. If for some reason you are unable to access your selected dentist or a Dental Health Services representative, you may seek palliative care — the relief of pain, swelling or bleeding — from any licensed dentist. You will be reimbursed for any amount over your applicable copayment for all dental work done to relieve pain, swelling, or bleeding.

What if I need to see a specialist?

Specialty coverage varies, depending on the plan in which you are enrolled. To determine if your plan offers specialty coverage, you may either reference the Evidence of Coverage brochure you receive upon your enrollment, or contact your Member Service Specialist.

936 N 34th Street, Suite 208 Seattle, WA 98103 800.637.6453 www.dentalhealthservices.com

Enrollment Form

Last Name	First Name	M.I.	Social Security #
Address	City	State	Zip Code
E-mail Address	Home Phone	Work Phone	Birth Date

Dentist Number – numeric code next to dentist name in directory

Requested Effective Date
(Enroll by the last day of the month to be eligible on the first day of the following month)

Sex
☐ Male
☐ Female

OFFICE USE ONLY

W1532 — Group #

07/01/2017 — Effective Date

Dependents to be covered*

Last Name	First Name	M.I.	Sex	Relationship	Birth Date

*Dependents include your spouse, domestic partner, and/or children under 26 years of age. Children 26 years of age and over are eligible only while the child is and continues to be both 1) incapable of sustaining employment by reason of developmental disability or physical challenge, and 2) is chiefly dependent upon the subscriber for support and maintenance, provided proof of incapacity and dependency is furnished to Dental Health Services within 31 days of such a request.

By submitting this form, I authorize my dentist to release any information regarding patient history to Dental Health Services, consulting professionals, or other entities designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating, or administering benefits. The authorization remains in effect until revoked by me in writing. I also certify that I am at least 18 years of age.

It is a crime to knowingly provide false, incomplete, or misleading information to a limited healthcare service contractor for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of benefits.