Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 800-668-1703 fax: 800-668-6163

Step 2

SELECT THE TYPE OF BILLING YOU WANT – annually – once a year (by checking account deduction or credit card).
Send a voided check for your 1st months premium.

Step 3

SEND THE COMPLETED APPLICATION TO:

Teague Insurance Services

4710 4th St #300

La Mesa, CA 91941

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 800-668-1703

Thank you for choosing...

Vision Monthly Rates

	Choice Plan	Exam Plus
Member	$8.99	$3.00
Member + 1	$18.00	$6.00
Member + Family	$28.99	$9.00

Application Step 1

Benefits Association Enrollment Form: *(Signature Required)*

Social Security No.	Primary Enrollee: Last Name First Initial	Birthdate	Sex ❑ M ❑ F
Home Phone	Street		
	City State Zip		

"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthy membership fee is $1.00 and is included in the monthly rates."

Member Signature:

_____

Date _____

Sign Here

Application Step 2 Dental For Everyone Enrollment Card

Plan Selection: ❑ Diamond Plan ❑ Platinum Plan ❑ Gold Plan
Network Selection: ❑ Delta Dental Premier® ❑ Delta Dental PPO
Type of Coverage: ❑ Member ❑ Member + 1 ❑ Member + Family
Optional Vision Coverage: ❑ Exam Plus ❑ Choice Plan

Social Security No.	Primary Enrollee: Last Name First Initial	Birthdate	Sex ❑ M ❑ F
Home Phone	Street		
	City State Zip		
	E-mail address:		

LIST ALL DEPENDENTS TO BE COVERED BELOW

Last Name (if different) First Name Initial	Birthdate	Sex
2. Spouse		❑ M ❑ F
3. Dependents		❑ M ❑ F
4.		❑ M ❑ F
5.		❑ M ❑ F
6.		❑ M ❑ F
7.		❑ M ❑ F

METHOD OF PAYMENT

❑ Annually ❑ Quarterly ❑ Monthly

❑ Bankdraft: This is my authorization for Morgan-White Administrators, Inc., to draft payments from my checking account for payment of my insurance premiums. Below is the Routing Number and Checking Account number for the account on which drafts are to be drawn.

_____
Name of Bank

_____
Name as it appears on Check:

_____
Routing Number
(Bottom Left Corner of Check)

_____
Account Number
(2nd set of numbers on bottom)

❑ Visa ❑ Mastercard

_____
Credit Card Number

Exp. Date _____/_____
MM YY

Security Code _____
(3 digit code on back of card)

Total Amount Paid:_____

"I understand and agree that (1) the insurance shall not take effect unless the enrollment has been aceepted and approved (2) the agent does not have the authority to make or alter any contract or waive any other rights or requirements associated with this plan(s)."

Association Member's Signature _____ Date _____

For Agent Use Only

AGENT NAME (if applicable): Shirley Sankey

AGENT # (Your state license #): 330290797