

Carrier: _____

Plan: _____

BENEFIT AUTHORIZATION

* Your healthplan consists of 2 components. The first component is a fully insured Basic PPO plan with a \$1000 deductible and 80/20 coinsurance. The second component is a self-funded employer sponsored plan in which the employer sets plan benefits and limitations. Use the form below to give specific benefits, limitations, and directions to Ben-e-lect.

Client Information:

Client Name: _____ Employer Federal Tax ID: _____

Principal: _____ Contact: _____
Name/Title Name/Title

Phone: _____ Fax: _____ Email Address: _____

Benefit Information:

Deductible: _____ In-Network Coinsurance: _____ Supplemental PPO Network: INTERPLAN CFMC

Physician Office Visits: Copay: _____

Lab/Xrays: Coinsurance: _____ Limitation: \$1000 \$1500 (other) \$_____ per year

Accupuncture: Co-pay \$25 (other) _____ Visits per year: 12 (other) _____

Chiropractic Services: Co-pay \$25 (other) _____ Visits per year: 12 (other) _____

Physical Therapy Services: Coinsurance: _____ Annual Max: \$1000 (other)\$_____

DME/Medical Supplies: Coinsurance: _____ Annual Max: \$1000 (other)\$_____

Mental Health/Chem. Depend.

Out-Patient Services: Co-pay: \$25 (other) _____ Visits per year: 20 (other) _____

Wellcare:

Children (includes regular checkups & immunizations) Co-pay: \$25 (other) _____ Annual Max: \$500 (other) \$_____

Adults (includes office visit, pap, mammogram, PSA) Co-pay: \$25 (other) _____ Annual Max: \$250 (other)\$_____

Do you wish to pay the Carrier inpatient admission charge? NO YES (Charge will be payable at regular plan coinsurance level)

Do you wish to have an annual plan maximum per individual in lieu of the specific benefit maximums listed above? NO YES, \$_____ per year

(PLEASE NOTE: THIS LIMIT IS IN ADDITION TO AMOUNTS PAID UNDER THE PRESCRIPTION DRUG BENEFIT)

PRESCRIPTION DRUG BENEFIT- Generic Co-pay _____ Brand Co-pay _____ Limitation: \$1000 \$2000 (other)\$_____ per year

*Limits set on this benefit apply to prescription expenses only and benefits payable are in addition to any other plan limit or maximum specified above. Employer's prescription plan applies only after Carrier's \$500 per year prescription plan is exhausted.

Additional Benefit Specification: _____

Funding Type (check one) : _____ Standard - starting with check# _____ (if no # is indicated, we will default to # 101)
_____ Deposit (\$25 monthly fee) \$ _____ - \$ _____ - \$ _____ = \$ _____
Current Premium New Premium Admin. Fees Deposit (Min. \$2500)

I have reviewed and approve the benefit structure outlined above. I understand there is no guarantee of maximum liability to the employer when self-funding benefits of this nature other than the specific annual benefit maximums per individual set above. I understand that Ben-e-lect will administer the plan on our behalf only as directed in our plan's Schedule of Benefits or as specified above. .

Signature of Authorized Company Representative: _____ Date: _____/_____/_____

Contact for additional underwriting requirements: _____

Make commissions payable to: _____ Tax ID#: _____

Broker Signature: _____ Date: _____/_____/_____