



MES VISION APPLICATION

Please type or print in black ink

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|--|---|---|--------------------------|-------------------------|---------------------------------|
| California Association of Realtors® | | CARRIER: 00225 | | MES Group Number: 23540 | |
| SUBSCRIBER INFORMATION | | | | | |
| Social Security Number ____/____/____ | Requested Subscriber Effective Date ____/____/____ | C.A.R. Join Date/ Date of Hire ____/____/____ | CA Real Estate License # | | |
| Last Name | | First Name | | MI | Date of Birth ____/____/____ |
| Home Address | | City | | State | Zip |
| Billing Address (if different than home) | | City | | State | Zip |
| Home Phone | Business Phone | Cell Phone | EMAIL Address | | |

LIST BELOW ALL ELIGIBLE DEPENDENTS WHO ARE ENROLLING

Coverage granted to individuals listed hereon shall be subject to all provisions and limitations of the MESVision evidence of coverage.

| Relationship | First Name | MI | Last Name | Date Of Birth | Sex |
|--|------------|----|-----------|---------------|-----|
| <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner | | | | | |
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I certify that all dependent children listed above who are age 19 to 26 years are full-time students (*A full-time student is a student who is enrolled for a minimum of 12 units.*) attending an accredited college, university, vocational or technical school, and fully dependent upon me for support according to IRS guidelines.

SIGNATURE

DATE

PRINT EMPLOYER/C.A.R. MEMBER NAME (if subscriber is W-2 employee)

PLEASE RETURN THIS FORM TO REALCARE

RealCare Insurance Marketing, Inc.
19310 Sonoma Highway, Ste. A
Sonoma, CA 95476

Phone: (800) 939-8088, Ext. 202 — Fax: (707) 935-7142



Application Checklist

- Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- Enclose initial month's premium payment (**even if you are selecting the Automatic Premium Payment option**). Include premiums for all applicable insurance plans (medical, dental, vision, and life insurance). If you are enrolling with Anthem Blue Cross, you may be required to **send two months of premium with your application**. After your initial payment you will pay a single monthly premium. Please check with your agent, or call RealCare, to confirm the minimum payment due with your application.
- Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- If you are choosing the Automatic Premium Payment method, enclose a **voided check** and complete the form below and return to RealCare with your initial premium check. **The initial premium must be submitted even if you select the Automatic Premium Payment option.**
- Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- Have questions or need assistance? Call 1-800-939-8088 Ext. 202

**Mail Applications to:
RealCare Insurance Marketing, Inc.
19310 Sonoma Hwy. Ste. A
Sonoma, CA 95476**

MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to pay and charge to my account indicated below checks drawn on that account by and payable to the order of RealCare Insurance Trust Account (RITA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my health care dues and/or insurance premiums, adjustments and administration fees due. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

If I am enrolled in an Anthem Blue Cross plan, payments will be debited from my account on the first of the month following the due date. If I am enrolled in a Kaiser plan or only enrolled in a dental, vision, and/or life insurance plan, payments will be debited from my account on the fifth of the month following the due date. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

| | |
|--|----------------------|
| <i>Policyholder Information</i> | |
| Policyholder name: _____ | Phone: _____ |
| Social Security Number: _____ | Email Address: _____ |

**PLEASE
ATTACH A
COPY OF
YOUR VOIDED
CHECK AND
SUBMIT WITH**

| | |
|--|--|
| <i>Banking Information</i> | |
| Name of bank or financial institution: _____ | |
| Bank Account Name: _____ | |
| <input type="checkbox"/> Checking Account | <input type="checkbox"/> Savings Account |
| Account Number: _____ | |
| Bank Routing Number: _____ | |

**YOUR
ENROLLMENT
APPLICATION.**

| | |
|--|-------------|
| <i>Authorized Signature</i> | |
| _____ | Date: _____ |
| Authorized Signature <i>(As it appears in the financial institution's records)</i> | |