



**FBP BUSINESS SERVICES ASSOCIATION  
PRODUCER CHECKLIST:**

The following documentation must be submitted to properly process a new account:

- APPLICATION FOR MEMBERSHIP** and cost calculation
- APPLICATION FOR SMALL EMPLOYER HEALTH BENEFITS** completed with selected coverages and signed by a company official (original copy only)\*
- SMALL EMPLOYER CERTIFICATION** completed and signed ( original copy only)\*
- ENROLLMENT CHANGE FORM(s)** completed and signed (original copy only)\*
- Full first month's payment enclosed** (Check made payable to FBP)
- Proof of Business** - UC-2A or Schedule C (see proof of business requirements on the back of this page)
- PRE-AUTHORIZED CHECK-O-MATIC PLAN** form

**PRODUCER certifies that he/she has personally solicited this applicant and assisted in the completion of the enclosed forms and has no knowledge of any material facts that would affect the issuance of coverage on this applicant.**

Producer Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Please print Producer Name: \_\_\_\_\_

Email address: \_\_\_\_\_

Firm Name: \_\_\_\_\_

Producer Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Make Commissions Payable to: \_\_\_\_\_ Tax Number: \_\_\_\_\_

If this is your first FBP case, please be sure to include a copy of your license, a completed W-9, and a copy of your E&O insurance face page. **All advertising must be approved in advance by Flexible Benefits Plans, Inc. and the carrier.** For details, please visit [www.flexiben.com](http://www.flexiben.com).

\* IBC will not accept faxed or scanned copies. Only completed original forms will be accepted and processed.

## **Proof of Business Requirements**

**These items are acceptable to Independence Blue Cross and Keystone Health Plan East to verify a business entity:**

### **Personal Choice or Keystone groups of two (2) or more**

- The most recent Pennsylvania unemployment compensation report (UC-2A) signed by a company official (the report should list all of the employees)

### **Keystone Sole Proprietors**

- The most recent schedule C report filed with the IRS

### **One-sub professionals<sup>†</sup>**

- A copy of the professional license and proof of income from that license.

**If these types of business documentation are not available, please contact Flexible Benefits Plans, Inc. In some cases it will be necessary to fill out a census form and submit further proof of business.**

**Please note that to qualify for Independence Blue Cross or Keystone Health Plan East Coverage, a company must be domiciled in the five-county Philadelphia area.**

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<sup>†</sup> The back of the Application For Membership page has a complete list of eligible professionals



## NEW MEMBER APPLICATION

Thank you for your interest in our association. This document explains the steps needed to join the FBP Business Services Association and elect your new health insurance coverage. Please do not hesitate to contact our office with any questions.

In order to process your application in a timely and accurate manner, please submit the following:

1. **APPLICATION FOR MEMBERSHIP** to the association.
2. The **APPLICATION FOR SMALL EMPLOYER HEALTH BENEFITS** form. Please complete and sign this form to identify your group benefit elections. It's important that this information is accurate and complete so we can provide you with the correct coverage (original copy only.)<sup>‡</sup>
3. **PROOF OF BUSINESS:**
  - a. **Groups of 2 or more employees** are required to submit a signed copy of the latest **PA UC-2A** report (quarterly unemployment payment/list to the Commonwealth). Please contact us if yours is a new business and you have not filed a **PA FORM UC-2A**.
  - b. **Sole proprietors or independent business owners** applying for the Keystone Sole Proprietor Plan are required to submit a copy of their most recent **Schedule C**.
4. **ENROLLMENT AND CHANGE FORM** for each employee applying for coverage. Please consult this office if you are applying for more than one plan of benefits for your employees. Include Small Employer Health Benefits Waiver of Coverage for those eligible employees who are waiving coverage. (original copy only)\*
5. **PRE-AUTHORIZED CHECK-O-MATIC PLAN** application (required for all one-life groups).
6. **CHECK FOR 1<sup>ST</sup> MONTH'S PREMIUM**. A worksheet for the cost calculation of the check is included in the Application for Membership form (#1, above). (Check made payable to FBP)

### PLEASE NOTE:

**The effective date of a new account must be the first of the month.** We cannot accept a new group submitted after the 10<sup>th</sup> of the month prior to the chosen effective date due to processing time requirements. **Please note that to qualify for Independence Blue Cross or Keystone Health Plan East Coverage, a company must be domiciled in the five-county Philadelphia area.**

Once all of the above information has been gathered and submitted by us to the carrier(s) for underwriting review, you will be notified of their decision within two to three weeks. **It is important that you do not cancel any health insurance policy that you may already have until you receive written notice of acceptance from this office.**

Once you receive notification of acceptance, it will take another one to two weeks for the carrier(s) to get you your Subscriber Agreement and ID cards. You will also receive your Dental and Vision card(s) (if applicable) directly from CAREington International and Eye Care Plan of America, and a **MEMBER BENEFIT KIT** directly from this office.

Once again, we'd like to thank you for your interest in the FBP Business Services Association. If you have any questions regarding any of the procedures outlined above, please visit our web site at [www.flexiben.com](http://www.flexiben.com) or call us **TOLL FREE** at (800) 892-1120.

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## **Proof of Business Requirements**

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### **Keystone Sole Proprietors**

- The most recent schedule C report filed with the IRS

### **One-sub professionals<sup>§</sup>**

- A copy of the professional license and proof of income from that license

**If these types of business documentation are not available, please contact Flexible Benefits Plans, Inc. In some cases it will be necessary to fill out a census form and submit further proof of business.**

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<sup>§</sup> The back of the Application For Membership page has a complete list of eligible professionals



Flexible Benefits Plans

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:** \$ \_\_\_\_\_

Please note billing fee of \$10, \$15, or \$20  
(see pricing sheet)

**Billing Fee:** \$ \_\_\_\_\_  
**Association Dues:** \$7.50

**Monthly Total:** \$ \_\_\_\_\_  
**Joinder Fee:** \_\_\_\_\_

**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: \_\_\_\_\_

# Groups of one

The following **licensed professionals** may enroll as a "group of one" in **any** Keystone Health Plan East or Independence Blue Cross/Pennsylvania Blue Shield program:

**Each "group of one" must show their current PA License and proof on income from that License.**

**Accountants (CPA)**

**Osteopathic Doctors**

**Architects**

**Certified Paralegals**

**Attorneys**

**Pharmacists**

**Chiropractors**

**Physical Therapists**

**Dentists**

**Podiatrists**

**Engineers**

**Psychologists**

**Funeral Directors**

**Real Estate Agents, Brokers and Appraisers**

**Ministers**

**Social Workers**

**Medical Doctors**

**Speech Language Therapists**

**Nurses**

**Navigation Commissioners**

**Nursing Home Administrators**

**Veterinarians**

**Occupational Therapists**

**Insurance Agents (limited to CLU, CEBS, ChFCs or CPCU)**

**Optometrists**

**Certified Financial Planner**

**Licensed Midwives**

**Cantors**

**Ordained Seminary Graduates**



# PRE-AUTHORIZED CHECK-O-MATIC PLAN

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

*Authorization to Honor Checks/Debits by Flexible Benefits Plans, Inc. /FBP Business Services Association.*

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 checks/electronic debits drawn on my account by Flexible Benefits Plans, Inc./FBP Business Services Association 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 check/electronic debit.

I agree that your treatment of each such check/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 check/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
<b>Debits are transacted on the 1<sup>st</sup> business day of each month.</b>	_____ Checking Account Number you wish us to debit

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