

# 10 Steps to Insurance Enrollment

## **Step 1:** Gather your materials

1. Social Security number of all dependents you plan to enroll.
2. Date of birth of all dependents you plan to enroll.
3. Your form of payment (credit/debit card/routing and account numbers).  
**\*\*There is a processing fee of \$2.95 for checking or savings account bank draft and a minimum of \$2.95 or 3.5% for a credit / debit card payment.**
4. Add [info@lockardandwilliams.com](mailto:info@lockardandwilliams.com) to your email contacts to keep emails from going to your junk mail folder.

**Process must be completed by March 28, 2019.**

**Payment will be drafted the first week of each month beginning in April.**

**Coverage Starts on May 1, 2019.**

**For Enrollment Form Questions: 228-762-2500  
For BCBS Plan Questions: 1-800-292-8868 (Group #: 58179)**

**Step 2:** Click this link and fill out all information:

<https://90degreebenefits.com/forms/member-info.php>

On the Member ID line, please enter "0000"



## Member Information Form

Dear Member:

Your association sponsors a health, dental and vision plan through BlueCross BlueShield of Alabama.

To begin the enrollment process, complete the below information and click the Submit button. 90 Degree Benefits will be acting as the enrollment manager for the association plans. The information you provide below will allow 90 Degree Benefits to create a personalized username and password that will be sent to the email you provide below. This username and password will allow you to enter the enrollment system to complete your enrollment in the new association plans.

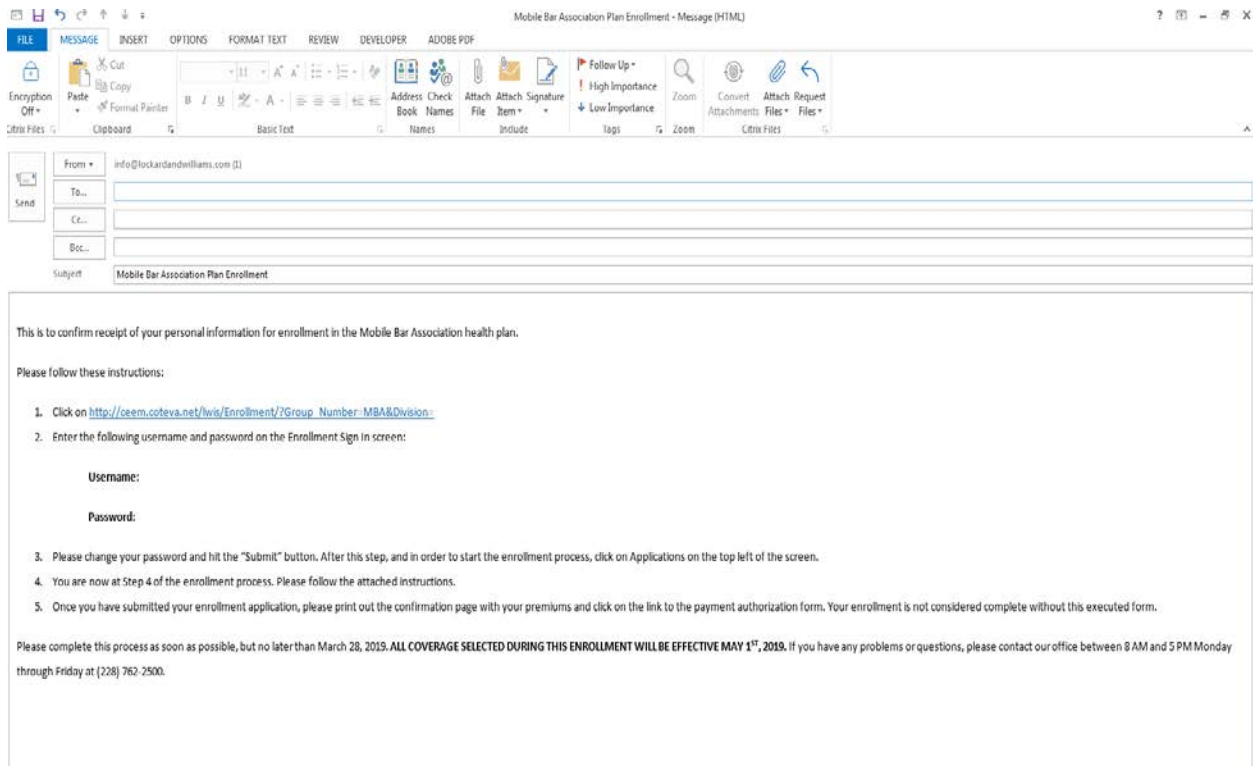
|                                                                                                                                                                           |                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Name</b></p> <p>First <input type="text"/></p> <p>Middle <input type="text"/></p> <p>Last <input type="text"/> Suffix <input type="text"/></p>                      | <p><b>Address</b></p> <p>Street <input type="text"/></p> <p>City <input type="text"/></p> <p>State <input type="text" value="Alabama"/></p> <p>Zip <input type="text" value="XXXXX"/></p> |
| <p><b>Association Name</b></p> <p><input type="text"/></p>                                                                                                                | <p><b>Mobile Phone</b></p> <p><input type="text" value="0000 XXX-XXXX"/></p>                                                                                                              |
| <p><b>Member ID</b></p> <p><input type="text" value="0000"/></p>                                                                                                          | <p><b>Work Phone</b></p> <p><input type="text" value="0000 XXX-XXXX"/></p>                                                                                                                |
| <p><b>Date of Birth</b></p> <p><input type="text" value="MM/DD/YYYY"/></p>                                                                                                | <p><b>Email Address</b></p> <p><input type="text" value="Valid Email Address"/></p>                                                                                                       |
| <p><b>Social Security Number</b></p> <p><input type="text" value="XXX-XX-XXXX"/></p>                                                                                      |                                                                                                                                                                                           |
| <p><b>Gender</b> <input checked="" type="radio"/> Male <input type="radio"/> Female</p>                                                                                   |                                                                                                                                                                                           |
| <p><b>Marital Status</b> <input checked="" type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Legally Separated</p> |                                                                                                                                                                                           |
| <p><b>Submit</b></p>                                                                                                                                                      |                                                                                                                                                                                           |

90 Degree Benefits  
A Turn For The Better

228.762.2500  
450 Riverchase Parkway East  
Birmingham, Alabama 35244

**For Enrollment Form Questions: 228-762-2500**  
**For BCBS Plan Questions: 1-800-292-8868 (Group #: 58179)**

**Step 3:** Once submitted, you'll receive an email (from [info@lockardandwilliams.com](mailto:info@lockardandwilliams.com)) within 48-72 hours with your username and password. Use the link provided in the email.



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**Step 4:** Click on the link you have received in the email using Internet Explorer or FireFox. Do **NOT** use Google Chrome. Log in using the credentials in your new email; you will be prompted to create a new password. It must contain all of the following:

- a. At least 8 characters
- b. 1 uppercase letter
- c. 1 lowercase letter
- d. 1 number

Employee Enrollment Applications Help RBURGESS0768

**150<sup>th</sup> Anniversary**  
**MBA**  
MOBILE BAR ASSOCIATION  
EST. 1869

### My Account > Settings

**Change Password** ✕  
You must select and enter a new password in the form below to replace the temporary password issued by the system before continuing. The new password must be at least 8 characters and include at least one upper case letter (A-Z), one lower case letter (a-z) and one number (0-9)

**Change Password**

Current password  
\*\*\*\*\* <- Enter password provided in email here

New password  
\*\*\*\*\*  show password

Reenter password  
\*\*\*\*\*  show password

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**Step 5:** Once you changed your password, you'll click on **APPLICATIONS** in the top left corner.

Employee Enrollment **Applications** Help RBURGESS0768

150<sup>th</sup> Anniversary  
**MBA**  
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EST. 1869

### My Account > Settings

All passwords must be at least 8 characters and include at least one upper case letter (A-Z), one lower case letter (a-z) and one number (0-9).

Change Password

Password successfully reset

Current password  
New password  show password  
Reenter password  show password

Submit

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Begin enrollment application.

Employee Enrollment **Applications** Help RBURGESS0768

150<sup>th</sup> Anniversary  
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EST. 1869

### Employee Enrollment

**Employer Summary**

|               |                        |
|---------------|------------------------|
| Company Id    | 1000                   |
| Group Number  | MBA                    |
| Group Name    | MOBILE BAR ASSOCIATION |
| Division ID   | 0001                   |
| Division Name | ACTIVE                 |

**Employee/Participant**

RACHAEL BURGESS  
P O BOX 1688  
PASCAGOULA, MS 39568  
PHONE: N/A

MEMBER ID#: 010100101

**Employer Group**

MOBILE BAR ASSOCIATION  
P O DRAWER 2005  
MOBILE, AL 36652  
(251) 433-9790

GROUP#: MBA : 0001

**Open Applications**

The following open or incomplete enrollment applications are currently available to be completed. To complete the item, select the application icon to the right of the item's status. For further instructions, select the instructions icon in the far right column.

| Open Item                                                           | Created      | Status | Application | Benefits Information |
|---------------------------------------------------------------------|--------------|--------|-------------|----------------------|
| <a href="#">Click Here to Start/Complete Enrollment Application</a> | FEB 19, 2019 | OPEN   |             |                      |

**Document/Forms Library**

**Step 6:** Enter dependents (if applicable)

**For Enrollment Form Questions: 228-762-2500**  
**For BCBS Plan Questions: 1-800-292-8868 (Group #: 58179)**

https://ceem.coteva.net/wis/dbt-enrollment.php?

Dependents

Please complete this section only for the dependent(s) you wish to enroll in coverage. Please provide Social Security numbers for all dependents, as failure to do so may delay your enrollment. If you do not wish to enroll any dependents, please click the Save and Continue button to move to the next screen.

Dependents to Enroll

Dependent Date of Birth

← Previous Save & Continue →

**Add Dependent**

DEPENDENT #01

NAME First Name MI Last Name

DOB MM / DD / YYYY

SSN

GENDER

RELATIONSHIP

ADDRESS P O BOX 1688

ADDRESS 2 Ftr/Suite/Room

CITY/STATE/ZIP PASCAGOUL MS 39568

Save Close

Review dependent information before moving on.

https://ceem.coteva.net/wis/dbt-enrollment.php?

Participant Dependents Core Details Summary Details Add/Save Review Help Per Pay \$0.00

Dependents RACHAEL BURDESS / MBA - 0901 / ENROLLMENT# 4329

Please complete this section only for the dependent(s) you wish to enroll in coverage. Please provide Social Security numbers for all dependents, as failure to do so may delay your enrollment. If you do not wish to enroll any dependents, please click the Save & Continue button to move to the next screen.

Dependents to Enroll

| Dependent   | Date of Birth | SSN       | Gender | Relationship | Disabled |
|-------------|---------------|-----------|--------|--------------|----------|
| 01 JANE DOE | 01/01/1980    | 000000000 | F      | C            |          |
| 02 JOHN DOE | 01/01/1980    | 000000000 | M      | S            |          |

← Previous **Save & Continue** → Add Dependent

**For Enrollment Form Questions: 228-762-2500**  
**For BCBS Plan Questions: 1-800-292-8868 (Group #: 58179)**

**Step 7:** You will now select your health benefits (if applicable). **For specific benefits questions, contact BCBS- 1-800-292-8868.**

Participant Dependents Core Benefits Voluntary Benefits Additional Services Help Per Pay: \$0.00

Medical Option 1

| Cov | Plan               | Enrollment Volume | Per Pay Deduction |
|-----|--------------------|-------------------|-------------------|
| MED | MBA_500_Deductible | Single - 572.26   | 572.26            |

Medical Option 2

| Cov | Plan                | Enrollment Volume | Per Pay Deduction |
|-----|---------------------|-------------------|-------------------|
| MED | MBA_3000_Deductible |                   |                   |

OR Decline Medical Coverage

DECLINE REASON:

DECLINE MEDICAL COVERAGE

Dependent Benefits

| No.                         | Dependent | Date of Birth | Gender | Relationship |
|-----------------------------|-----------|---------------|--------|--------------|
| <input type="checkbox"/> 01 | JANE DOE  | 01/01/1980    | F      | C            |
| <input type="checkbox"/> 02 | JOHN DOE  | 01/01/1980    | M      | S            |

← Dependents Save & Continue ▶

Now select your vision and dental voluntary benefits (if applicable). **For specific benefits questions, contact BCBS- 1-800-292-8868.**

Participant Dependents Core Benefits Voluntary Benefits Additional Services Help Per Pay: \$572.26

RACHAEL BURGESS / MBA / 0001 / ENROLLMENT 4035

This section will allow you to choose enrollment in the dental and/or vision coverage. Please select the appropriate plan for the dental and/or vision coverage from the drop down menu under Plan and Enrollment. The Per Pay Deduction is your monthly costs for the dental and vision coverage. There is also a \$3.00 administration fee for the dental coverage. Once you complete your enrollment click on Save & Continue.

Healthcare Benefits

| Cov                          | Plan                    | Enrollment | Per Pay Deduction |
|------------------------------|-------------------------|------------|-------------------|
| <input type="checkbox"/> DEN |                         |            | 0.00              |
| <input type="checkbox"/> VIS | MBA_VISION (MBA_VISION) |            | 0.00              |

Dependent Benefits

| Dependent | Date of Birth | Gender     | Relationship | DEN | VIS                      |                          |
|-----------|---------------|------------|--------------|-----|--------------------------|--------------------------|
| 01        | DOE, JANE     | 1980-01-01 | F            | C   | <input type="checkbox"/> | <input type="checkbox"/> |
| 02        | DOE, JOHN     | 1980-01-01 | M            | S   | <input type="checkbox"/> | <input type="checkbox"/> |

← Core Benefits Save & Continue ▶

**For Enrollment Form Questions: 228-762-2500**  
**For BCBS Plan Questions: 1-800-292-8868 (Group #: 58179)**

**Step 8:** You'll be asked to review and submit your application. Once submitted, your application will appear in a new window. (1<sup>st</sup> window remains open)

**PRINT THIS SCREEN FOR YOUR RECORDS.**

**You will need the total of your plans for your payment authorization.**

Application Summary

Personal Information

Name: RACHAEL BURGESS      Marital Status: M

Date of Birth: 10/15/1989

SSN: 101 01 5101

Gender: F

Contact Information

Street/PO Box: P.O. BOX 1088      Mobile Phone: 208 762 2500

City/State/Zip: PALCAOOLA, MS 39090      Work Phone: 220 795 2500

Email: admin@lockandswilliams.com

Benefits

| Cov | Plan               | Enrollment    | Volume | Employee Share | Per Pay Amount |
|-----|--------------------|---------------|--------|----------------|----------------|
| MED | MSA_500_Deductible | Single        | N/A    | 572.26         | 572.26         |
| DEN | MSA_DENTAL_BASIC   | Family        | N/A    | 58.50          | 58.50          |
| VIS | MSA_VISION         | EE Plus Child | N/A    | 11.22          | 11.22          |
|     |                    |               |        | *****          | *****          |
|     |                    |               |        | 641.98         | 641.98         |

Dependents

| Dependent   | Date of Birth | SSN       | Gender | Relationship | MED | DEN | VIS |
|-------------|---------------|-----------|--------|--------------|-----|-----|-----|
| 01 JANE DOE | 01/01/1980    | 000000000 | F      | C            | ✓   |     | ✓   |
| 02 JOHN DOE | 01/01/1980    | 000000000 | M      | S            |     | ✓   |     |

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**Step 9:** To make payment, click the link in the last paragraph of your application, or click here:

<https://90degreebenefits.com/forms/payment-auth.php>

**Your enrollment is NOT COMPLETE until you submit your payment authorization form and payment is made!**

Application Submitted

Secondary Beneficiaries

No Secondary Beneficiaries on Application

Other Insurance

| Name of Insured Person              | Medical Carrier | Dental Carrier | Vision Carrier | Medicaid/Medicare? |
|-------------------------------------|-----------------|----------------|----------------|--------------------|
| NO OTHER INSURANCE THIS APPLICATION |                 |                |                |                    |

Participant Signature

I understand that coverage elected during this enrollment process will be effective May 1, 2019.

To the best of my knowledge, the information I am providing is correct and I understand that if I provide false information, my claims may not be paid, payments may be recovered, plan eligibility/membership may be cancelled.

I authorize any insurance or services company related to benefit coverages referenced herein to obtain an ability to examine or release information needed to coordinate benefits or process claims for myself or my family. This electronic form supersedes all previous forms I have submitted. If I have waived coverage, I understand that satisfactory evidence of loss of other said coverage may be required to enroll at a later date.

My election or waiver of coverage is binding and cannot be revoked or modified during the plan year except for changes allowable by state or federal law (as explained in the plan document).

I understand that I must complete the payment authorization form with the premium for coverage, along with the administration fees for that coverage. This application must be completed and I must be in good standing with Mobile Bar Association, before I am approved for coverage. I also understand that credit card payments require a 3.5% payment processing fee or \$2.95 minimum fee, and ACH payments require a \$2.95 payment processing fee per draft and that the premium displayed above does not include the payment processing fee.

I understand that the authorization for charges will remain in full force and effect until I notify 90 Degree Benefits in writing that I wish to revoke this authorization. I understand that 90 Degree Benefits requires at least 2 weeks' notice prior to the proposed effective date of the debt in order to cancel this authorization. Payments will process on the first of each month.

I understand that payments will process on the third of each month, if the first is on a Saturday or Sunday, it will process on the next business day. Should my payment be rejected for Non-Sufficient Funds (NSF), I understand that 90 Degree Benefits will attempt to process the charge again 7 days from the original processing date, and I agree to any additional charge by the bank for each attempt returned NSF, which will be initiated as a separate transaction from the authorized payment. Should the payment be rejected on the second processing date, 90 Degree Benefits will terminate coverage effective at midnight the last day of the last period for which premiums were paid.

I understand that my application is not complete, until I submit my payment AND the payment authorization form. Once you have done so, I have electronically signed your enrollment application below and submitted as first, a pop up window will appear with a printable summary of the choices you have made including your premiums and fees. Please print this page. Then click on the following link: <https://www.90degreebenefits.com/forms/payment-auth.php> to access your payment authorization form. Use the Benefits and Administrative Benefits sections which display your premiums and fees, to complete your payment authorization form. Once completed, click the Submit button to send the form to 90 Degree Benefits.

I accept the above conditions for enrollment:

RACHAEL BURKES

DATE: 02/19/2019

Close Window Print Window Show SSIs

**\*\*Your signature MUST be ALL CAPS\*\***

**For Enrollment Form Questions: 228-762-2500**  
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**Step 10:** You will enter the premiums in the boxes of the payment authorization form and the admin fees will be automatically added to your total on the bottom. **On the Member ID line, please enter "0000"**



## Payment Authorization Form

You have two payment options: ACH (Debit your Account) or Debit/Credit Card.  
Please choose one of the options below.

ACH (Debit your Account)

Debit/Credit Card

Payment Authorization Form – By signing this form, I give 90 Degree Benefits permission to debit my account or charge my debit/credit card for the amount indicated below on the date of debit indicated below. I also agree to and authorize a debit from my account or charge to my debit/credit card for the bank-processing fee indicated below. I agree to and authorize these recurring (monthly) transactions.

\*A bank-processing fee of \$2.95 per transaction will be charged.

\*\*All fields are required.

|                                                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Account Type <input checked="" type="radio"/> Personal Checking<br><input type="radio"/> Personal Savings <input type="radio"/> Business Checking<br><input type="radio"/> Business Savings |  |
| Bank Name                                                                                                                                                                                   |  |
| Enter Bank Name                                                                                                                                                                             |  |
| Routing Number                                                                                                                                                                              |  |
| Enter Routing Number                                                                                                                                                                        |  |
| Account Number                                                                                                                                                                              |  |
| Enter Account Number                                                                                                                                                                        |  |
| *Date of Debit Each Month: 1st of Each Month                                                                                                                                                |  |
| Medical Premium                                                                                                                                                                             |  |
| Enter Medical Premium                                                                                                                                                                       |  |
| *A \$12.00 admin fee will be added to this amount.                                                                                                                                          |  |
| Dental Premium                                                                                                                                                                              |  |
| Enter Dental Premium                                                                                                                                                                        |  |
| *A \$3.00 admin fee will be added to this amount.                                                                                                                                           |  |
| Vision Premium                                                                                                                                                                              |  |
| Enter Vision Premium                                                                                                                                                                        |  |
| Total                                                                                                                                                                                       |  |
| \$XXX.XX                                                                                                                                                                                    |  |
| *Includes applicable admin fees.                                                                                                                                                            |  |
| Submit                                                                                                                                                                                      |  |

**Authorization** - I understand that this authorization will remain in full force and effect until I notify 90 Degree Benefits in writing that I wish to revoke this authorization. I understand that 90 Degree Benefits requires at least a 2 week notice prior to the proposed effective date of the debit in order to cancel this authorization.

**Non-Sufficient Funds Statement** - If the payment is rejected for Non-Sufficient Funds (NSF), I understand that 90 Degree Benefits will attempt to process the charge again 7 days from the original processing date, and I agree to any additional charge by the bank for each attempt returned as NSF, which will be initiated as a separate transaction from the authorized payment. Should the payment be rejected on the second processing date, 90 Degree Benefits will terminate coverage effective at midnight the last day of the last period for which premiums were paid.

**Acknowledgement** - I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I will not dispute 90 Degree Benefits' debit with my bank so long as the transaction corresponds to the terms indicated in this agreement.

Association Name

Enter Association Name

Member ID

Enter Member ID

Name (First, Middle, Last, Suffix if applicable)

Enter Your Full Name

\*This serves as your electronic signature.

Date Signed

03/01/2019

90 Degree Benefits  
A Turn For The Better

228.762.2500  
450 Riverchase Parkway East  
Birmingham, Alabama 35244

**A confirmation message will appear. Application is final with email confirmation or draft/credit card payment in the first week of April.**

**It is your responsibility to cancel your current insurance to avoid double coverage, effective April 30, 2019.**

**Coverage starts May 1, 2019**

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