EBIDS TSM v1.0.0 20140220
VER 20140220vf
REV 20220819vf

Employee Benefits Information Data Sheet

PRINT

Applicant Information:

This is a fillable application - please complete this first page

Benefits Start Date: *mm / dd / yyyy* ___/___/___

Social Sec. #: *000-00-0000* ___-___-___

First: _____ MI: _____ Last: _____

Address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

County: _____ Date of Birth: *mm / dd / yyyy* ___/___/___ Gender: ☐ M ☐ F

Home Phone: *123-456-7890* ___-___-___ Cell Phone: *123-456-7890* ___-___-___ Email: _____

Employer Information:

Date of Hire (or Your Company Start Date): *mm / dd / yyyy* ___/___/___

Owner of Company: _____ Choose a Tax ID Type: SSN *(000-00-0000)* FEIN*(00-0000000)*

(or Sole prop name)

Owner's Title: _____ Tax ID: N/A

Company: _____

Address: _____ Suite: _____

City: _____ State: _____ ZIP: _____

County: _____ Work Phone: *123-456-7890* ___-___-___ Work Fax: *123-456-7890* ___-___-___

Dependent Information:

	First Name	MI	Last Name	Gender	Date of Birth *mm / dd / yyyy*	Social Sec. # ***000-00-0000***
Spouse:				☐ M ☐ F	___/___/___	___-___-___
Child 1:				☐ M ☐ F	___/___/___	___-___-___
Child 2:				☐ M ☐ F	___/___/___	___-___-___
Child 3:				☐ M ☐ F	___/___/___	___-___-___
Child 4:				☐ M ☐ F	___/___/___	___-___-___

Date of Marriage: *mm/dd/yyyy* ___/___/___

Prior Coverage Information:

Prior Carrier: _____ From: *mm / dd / yyyy* ___/___/___ To: *mm / dd / yyyy* ___/___/___

Primary Care Doctor Name: _____

Primary Care Doctor (Spouse): _____ Referring Representative: Norman Michaels

Pediatric Doctor Name: _____ Today's Date: 06/28/2022

All information is kept confidential and will not be shared or used with any other company or organization.

Plan 8 - MagnaCare Ultra

Member Enrollment Form

CBG Chamber Benefits Group

A. Group Information (To be completed by the employer)				Please print neatly using black or blue ballpoint pen • ALL DATES MUST BE: MM/DD/YYYY
Group Number / Group Name	Plan CSP / Billing Group	Date of Hire / /	Effective Date / /	Occupation
☐ On Leave of Absence ☐ Union Employee ☐ Retired ☐ Disabled	COBRA/SC Qualifying Event	Event Date / /	**Employer Signature** X	Date / /

B. Applicant Details (To be completed by the employee)	Employee/Subscriber	Spouse	Child	Child
Social Security Number:	- -			
Last Name:				
First Name, Middle Initial:				
Date of Birth: (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Gender and Disability Status: (Check appropriate boxes.)	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled	☐ M ☐ F / ☐ Disabled
Primary Care Physician (PCP) ID Number: PCP Name: (If an existing patient of PCP, check "Yes".)	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Check all that apply:		☐ Domestic Partner	☐ Full-time Student	☐ Full-time Student
Prior Carrier (List coverage prior to this.) ☒ Same for all — Carrier: / Policy Number: / From Date / Thru date::	/ / / /	/ / / /	/ / / /	/ / / /

C. Coordination of Benefits		Employee/Subscriber	Spouse	Child	Child
Medicare Coverage	Check appropriate box and list effective date:	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /	☐ Part A / / ☐ Part B / / ☐ Part D / /
Pharmacy ☐ Same for all **Effective Date:** / /	Policy Number: / Carrier: / Policy Holder: / Group Number:	BIN: PCN:	BIN: PCN:	BIN: PCN:	BIN: PCN:
Medical ☐ Same for all	Policy Number: / Carrier: / Policy Holder: / Effective Date:	/ /	/ /	/ /	/ /

Employee's Address (Apt #)

City State Zip

Employee's Signature X

Date / /

Authorization Agreement for ACH Direct Withdrawals for Medical and Dental Plan Premium Payments

Company Name: _____

Company Address: _____

City, State & ZIP: _____

I (we) hereby authorize TriState Pay LLC to initiate debit entries to my (our) checking or savings account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of US law.

I (we) request that TriState Pay LLC process payments for the following:

Please check all that apply: ☐ Medical Premiums ☐ Dental Premiums ☐ Other

Depository Name:_____ Branch:_____

City:_____ State:_____ Zip:_____

Routing Number:_____ Account Number:_____

Please check ONE: ☐ Business Account ☐ Personal Account

Please check ONE: ☐ Checking Account ☐ Savings Account

This authorization is to remain in full force and effect until TriState Pay LLC has received written notification from me (us) of its termination in such time and in a manner as to afford TriState Pay LLC a reasonable opportunity to act on it.

Name(s) (Please print): _____

Signature: X_____ DATE Date:_____

NOTE: **INSUFFICIENT OR RETURNED ITEMS ARE SUBJECT TO A $25.00 FEE.**

PLEASE NOTE THAT MONTHLY PREMIUM INVOICES WILL STILL BE MAILED TO YOU FOR ADVICE PURPOSES ONLY.

ATTACH YOUR VOIDED CHECK HERE

Return to: TriState Pay LLC
75 N. Central Avenue, Ste. 200
Elmsford, NY 10523

OR

Return copy or scan of completed form and Voided Check
BY EMAIL to: vferrarajr@tristatepay.com
BY FAX to: 866 892-5001