Employer Agreement for List Billing

Application Instructions:

Thank you for your application for the BOST Advantage Card. Please follow the instructions below for a seamless application.

1) Complete the Employer Agreement for List Billing (on the next page)
2) Complete the census for all employees receiving the discount card
    a. The four digits at the end of the zip code is not necessary – just the zip code will suffice.
    b. Please enter the email if known. This will be used to ensure your employees are taking full advantage of the capabilities of the card.
    c. If you are able to pull a customized census, please match the necessary fields.
3) Email both forms as attachments to BAC@BOSTbenefits.com
4) Effective dates are requested on the Employer List Bill Agreement and should always be the first of month.
    a. Please allow 14 business days for processing and delivery of the cards and booklets.
5) Upon receipt of the above information, you will receive a confirmation email with additional information regarding billing, account management, and FAQ's. You will also receive an introductory phone call to answer any questions that you may have.

Please note: There is a 100% satisfaction guarantee on this product. You may cancel within the first 30 days for a full refund if you are not completely satisfied.

If you have additional questions, please email Sam Boore at sboore@BOSTbenefits.com or by phone at 1.877.283.7600 x208. You may also attend the webinar scheduled for May 2nd.

Thank you for your consideration of the BOST Advantage Card. We are happy to serve you!

Employer Agreement for List Billing

Agent Name and Email: Sam Boore / sboore@BOSTbenefits.com	**Group ID:** 16115	**Date:**

Internal Use Only

EMPLOYER INFORMATION			**BILLING CONTACT**
Company:			Name: Title:
Address:			Email: Fax:
Address 2:			**ELIGIBILITY CONTACT** ☐ **same as above**
City:	ST:	Zip Code:	Name: Title:
FEIN/TAX ID#:	Phone:		Email:
CARD PROGRAM			**HUMAN RESOURCES** ☐ **same as above**
Membership Effective Date:			Name: Title:
Number of Eligible Employees:			Email:
PAYMENT PROCESS			**MEMBERSHIP KITS SENT TO: circle/check one**
☒ ER Paid			☒**Employer**
Medical Base **Includes:** Teladoc (no consult fee), Vision, Aetna Dental Access®, Pharmacy, Diabetic Supplies, Hearing, Lab Tests, MRI & CT Scans			**Premium Package** **Includes:** Teladoc (no consult), Pharmacy, Lab Tests, MRI & CT Scans, Hearing, Aetna Dental Access, Vision, Diabetic Supplies, Legal Care Direct, ID Experts, Financial Helpline, Medical BillSaver, Medical Health Advisor, Nurse Hotline, Wellness, Telephonic Counseling, Pet Savings
☐ **$9.99 Employer Paid**			☐ **$24.49 Employer Paid**

New Benefits (NB) is the benefits administrator. NB will list bill Employer for all active employees enrolled on the last business day of the month (minimum of $50.00 per month). Employer agrees to pay NB by the twentieth (20th) day of each month. If Employer fails to pay NB by the twentieth (20th) NB may notify Employer in writing of such failure to pay and issue a warning to Employer that if payment in full for all previously billed amounts is not received within five (5) days from date of notice, NB may elect, without notice, to cease providing Employer's members access to the NB Membership Services pending receipt of payment.

Employer acknowledges and agrees they are not responsible for marketing the plan to its employees and is simply offering the plan as defined herein. Employer agrees it will not create, distribute or otherwise advertise the plan other than with those materials provided and approved by New Benefits. Employer has the right to discontinue it at any time after thirty (30) days advance notice, in which case the payment of dues will become a matter of arrangement between employee and NB. Employer does not undertake to handle the payment of any dues after termination of an employee's service, subject to notification of NB of the termination of such employee benefit(s).

The undersigned Employer agrees to the conditions printed above and assumes no liability other than as specified.

_____ _____

Signature Date (MM/DD/YY)

_____ **Agent/Reseller:** Sam Boore

Print Name and Title

Special Notes _____

Please submit this form to BAC@BOSTbenefits.com