

Steps to Insurance Enrollment

Step 1: The employer must complete the Certification of Compliance form and email it to Leanne@baldwinrealtors.com. The form can be found here: <https://bit.ly/BRAHPemployer>

Step 2: 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 membership with Baldwin Realtors must be in good standing. You do not have to be a member if your employer is a member. If you ARE the employer, you must be a member.
4. Your routing and account number, you wish to have debited. **There is no fee.**
5. Add Wendy.Witchen@90DegreeBenefits.com to your email contacts to keep emails from going to junk or clutter.

Step 3: Click this link and fill out all information:

https://90degreebenefits.formstack.com/forms/baldwin_realtor_member_informatin


Name *

<input type="text"/>	<input type="text"/>
First Name	Last Name

Address *

<input type="text"/>		
Address Line 1		
<input type="text"/>		
Address Line 2		
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State	ZIP Code

Date of Birth *

<input type="text"/>	<input type="text"/>	<input type="text"/>	
----------------------	----------------------	----------------------	---

Social Security Number *

<input type="text"/>

Mobile Phone *

<input type="text"/>

For Enrollment Form Questions: 228.762.2500
For BCBS Plan Questions: 855.249.3813 (Group #: 97643)

Step 4: Once submitted, you'll receive an email (from Wendy.Witchen@90DegreeBenefits.com) within 48-72 hours with your username and password. Use the link provided in the secure email to access your application.

This is to confirm receipt of your personal information for enrollment in the Baldwin Realtors association plan.

Please follow these instructions:

1. Click on https://ceem.coteva.net/lwis/Enrollment/?Group_Number=12
2. Enter the following username and password on the Enrollment Sign In screen (you may copy and paste the below):

Username:

Password:

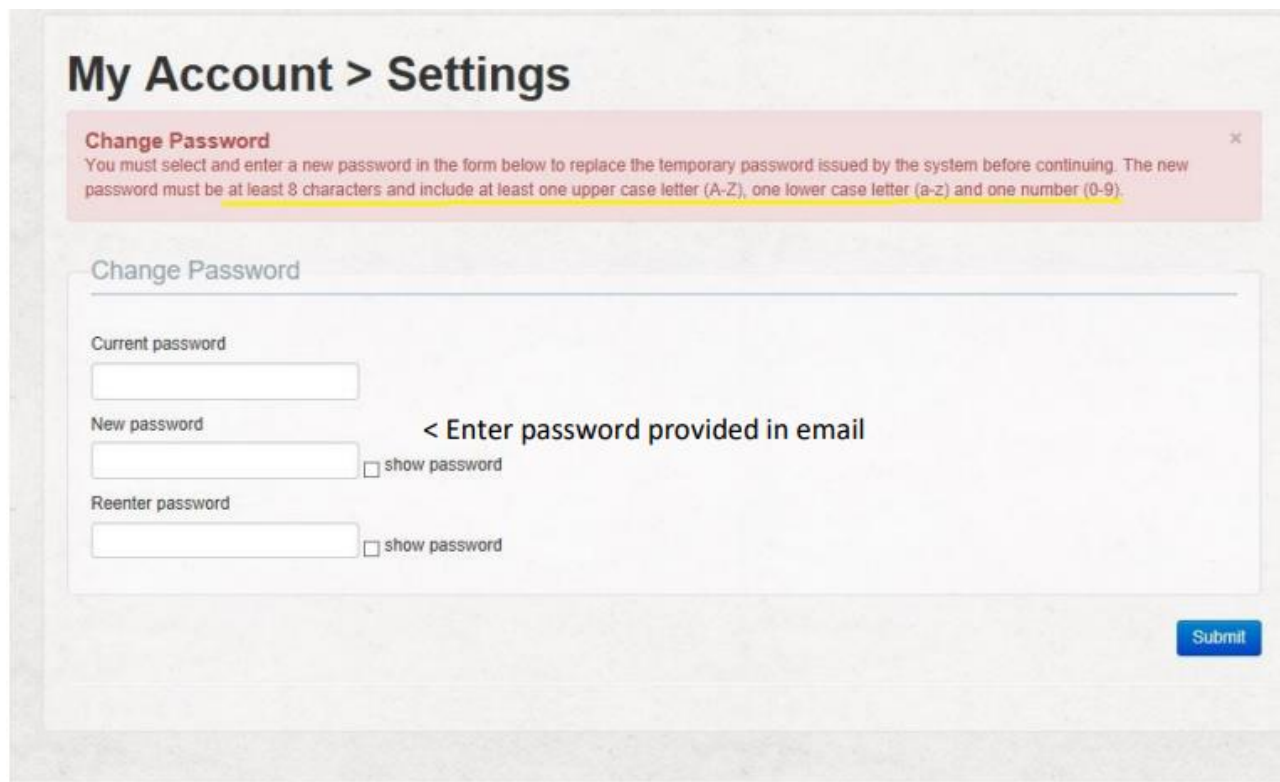
3. Please change your password and hit the "Submit" button. After this step, and in order to start the enrollment process, click on Applications on the top left of the screen.
4. You are now at Step 4 of the enrollment process. Please follow the attached instructions.
5. Once you have submitted your enrollment application, please print out the confirmation page with your premiums and click on the link to the payment authorization form. Your enrollment is not considered complete without this executed form.

Please complete this process as soon as possible, but no later than December 20, 2019. **ALL COVERAGE SELECTED DURING THIS ENROLLMENT WILL BE EFFECTIVE FEBRUARY 1, 2020.** If you have any problems or questions, please contact our office between 8 AM and 5 PM Monday through Friday at (228) 762-2500.

For Enrollment Form Questions: 228.762.2500
For BCBS Plan Questions: 855.249.3813 (Group #: 97643)

Step 5: Click on the link you have received in the email using your preferred web browser. Login using the credentials in your email. Please note the username and password are both case sensitive. It must contain:

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



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

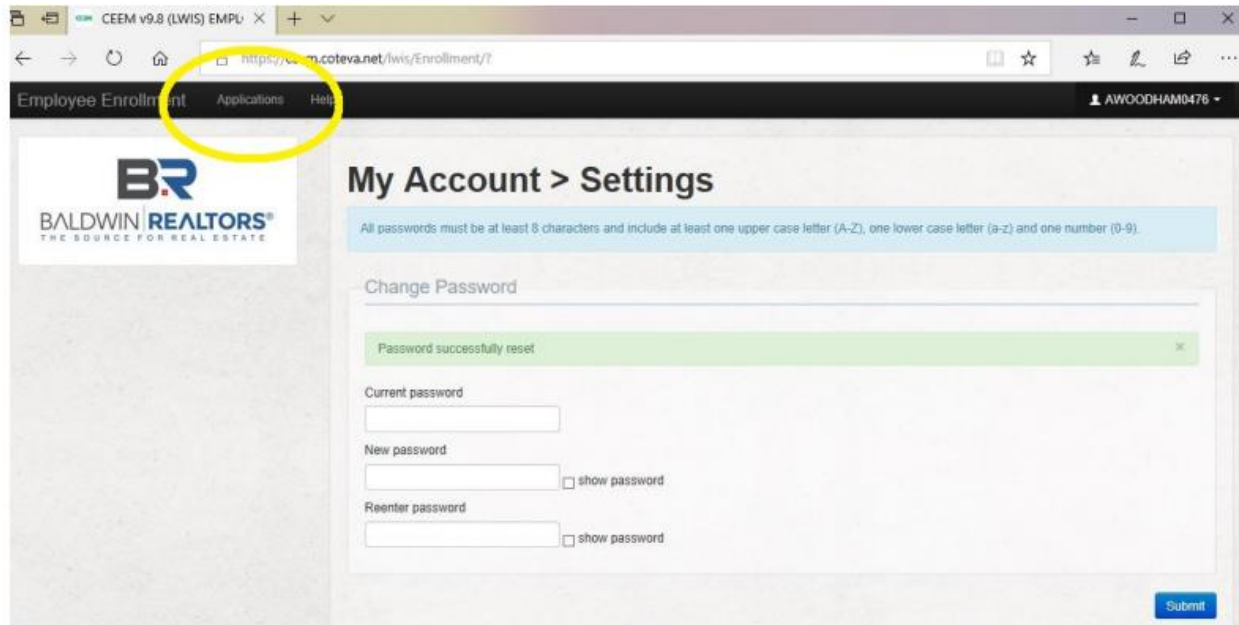
New password **< Enter password provided in email**
 show password

Reenter password
 show password

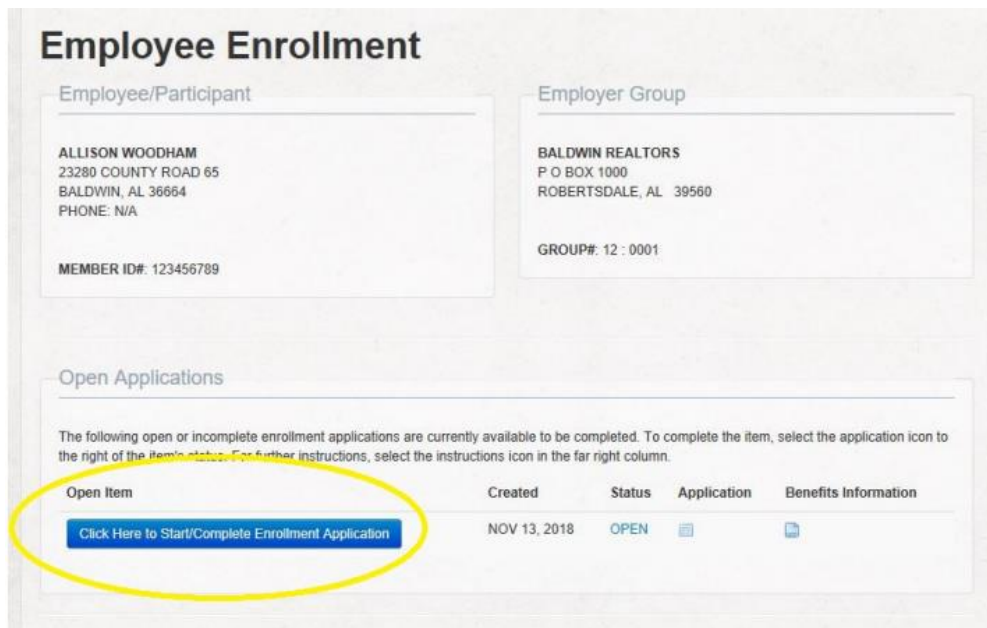
Submit

For Enrollment Form Questions: 228.762.2500
For BCBS Plan Questions: 855.249.3813 (Group #: 97643)

Step 6: Once you change your password, you'll click APPLICATIONS in the top left corner.



Step 7: Begin enrollment application



For Enrollment Form Questions: 228.762.2500
For BCBS Plan Questions: 855.249.3813 (Group #: 97643)

Step 8: Enter dependents (if applicable)

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	SSN	Gender	Relationship	Disabled
01 JANE DOE	12/20/1989	123458578	F	C	
02 JOHN DOE	09/10/1949	123457890	M	S	

[Add Dependent](#)

[Save & Continue](#)

Review dependent information before moving on.

Dependents ALLISON WOODHAM / 12 : 0001 / ENROLLMENT# 3197

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	SSN	Gender	Relationship	Disabled
01 JANE DOE	12/20/1989	123458578	F	C	
02 JOHN DOE	09/10/1949	123457890	M	S	

[Add Dependent](#)

[Participate](#) [Save & Continue](#)

For Enrollment Form Questions: 228.762.2500
For BCBS Plan Questions: 855.249.3813 (Group #: 97643)

Step 9: You will now select your Medical health benefits (if applicable). For specific benefits questions, contact BCBS: 800.292.8868

Core/Mandatory Benefits ALLISON HOOVER / 12 / 2021 / ENROLLMENT 2107

This section will allow you to choose the Blue Cross Blue Shield of Alabama option best suited for you. Please choose Medical Option 1 or Medical Option 2 and select the drop down window under Enrollment/Volume to select your coverage. The Per Pay Deduction is your monthly cost for the medical coverage. There is also a \$12.00 administration fee, which will display on the Review screen. Should you choose not to enroll in the medical coverage, you must select Decline Medical Coverage.

Medical Option 1

Cov: MED Plan: 3000_Deductible_BlueCare_PP0 Enrollment/Volume: Single - \$13.13, EE Plus Child - \$36.46, EE Plus Spouse - \$123.83, Family - \$213.85 Per Pay Deduction: []

Medical Option 2

Cov: MED Plan: 3000_Deductible_BlueCare_PP0 Enrollment/Volume: [] Per Pay Deduction: []

OR Decline Medical Coverage DECLINE REASON: []

DECLINE MEDICAL COVERAGE

Dependent Benefits

No.	Dependent	Date of Birth	Gender	Relationship
<input type="checkbox"/> 01	JANE DOE	12/29/1989	F	C
<input type="checkbox"/> 02	JOHN DOE	09/18/1949	M	S

[Previous](#) [Next & Continue](#)

Now select your vision and dental voluntary benefits (if applicable).

Core/Mandatory Benefits ALLISON HOOVER / 12 / 2021 / ENROLLMENT 2107

This section will allow you to choose the Blue Cross Blue Shield of Alabama option best suited for you. Please choose Medical Option 1 or Medical Option 2 and select the drop down window under Enrollment/Volume to select your coverage. The Per Pay Deduction is your monthly cost for the medical coverage. There is also a \$12.00 administration fee, which will display on the Review screen. Should you choose not to enroll in the medical coverage, you must select Decline Medical Coverage.

Medical Option 1

Cov: MED Plan: 3000_Deductible_BlueCare_PP0 Enrollment/Volume: Single - \$13.15, EE Plus Child - \$36.46, EE Plus Spouse - \$123.83, Family - \$213.86 Per Pay Deduction: []

Medical Option 2

Cov: MED Plan: 3000_Deductible_BlueCare_PP0 Enrollment/Volume: [] Per Pay Deduction: []

OR Decline Medical Coverage DECLINE REASON: []

DECLINE MEDICAL COVERAGE

Dependent Benefits

No.	Dependent	Date of Birth	Gender	Relationship
<input type="checkbox"/> 01	JANE DOE	12/29/1989	F	C
<input type="checkbox"/> 02	JOHN DOE	09/18/1949	M	S

[Previous](#) [Next & Continue](#)

For Enrollment Form Questions: 228.762.2500
For BCBS Plan Questions: 855.249.3813 (Group #: 97643)

Step 10: Before submitting your application, please confirm your selections. Once submitted, you may print your application for your records.

Step 11: You must go to this link and complete the bank authorization before you are enrolled.

https://90degreebenefits.formstack.com/forms/baldwin_reators_bank_draft_form

90 Degree Benefits
Post Office Box 1688
Pascagoula, Mississippi 39568-1688

RECURRING ACH PAYMENT AUTHORIZATION FORM

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a recurring transaction set forth by 90 Degree Benefits, dba Lockard & Williams Insurance Services, Inc. (L&W) and agreed upon by the member entering this agreement.

I authorize 90 Degree Benefits/L&W to debit the bank account indicated on this form, for the noted amount on the monthly billing notice.

1. AUTOMATED CLEARING HOUSE (Debit your Account)

Date of the debit: 1st of each month (plus bank processing fee)

Member Name

First Name	Last Name

Account Type

Checking Account Savings Account

Bank Name

Bank Routing Number

Bank Account Number

I understand that this authorization will remain in full force and effect until I notify 90 Degree Benefits/L&W in writing that I wish to revoke this authorization. I understand that L&W requires at least 2 weeks' notice prior to the proposed effective date of the debit in order to cancel this authorization.

If the payment is rejected for Non-Sufficient Funds (NSF), I understand that 90 Degree Benefits/L&W will attempt to process the charge again upon notification by our office. 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/L&W will terminate coverage effective at midnight the last day of the last period for which premiums were paid.

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/L&W's debit with my bank so long as the transaction corresponds to the terms indicated in this agreement.

Business Name

Contact Name

--	--

It is your responsibility to cancel your current insurance to avoid double coverage.

For Enrollment Form Questions: 228.762.2500
For BCBS Plan Questions: 855.249.3813 (Group #: 97643)