

HealthFlex Rx Instruction sheet for all employer groups who would like to enroll via monthly ACH, monthly Credit Card withdrawal or monthly list bill.

ALL GROUP BUSINESS MUST BE SUBMITTED NO LATER THAN 7 BUSINESS DAYS PRIOR TO THE REQUESTED ELIGIBILITY DATE.

GROUPS WITH 2-5 ENROLLING EMPLOYEES CAN ENROLL VIA A MONTHLY ACH OR CREDIT CARD WITHDRAWAL:

1. Complete a Group Summary Form & have employees complete an Employee Enrollment Application.
2. Mail the completed Group Summary Form and accompanying Employee Applications to NDHS at 37 Cannon Range Road, Suite 200, Milmay, NJ 08340 no later than 7 business days prior to the requested eligibility date.

GROUPS WITH 5 OR MORE ENROLLING EMPLOYEES CAN ENROLL VIA A MONTHLY LIST BILL.

1. Complete a Group Summary Form & have employees complete an Employee Enrollment Application.
2. Make the check for the first months membership fees payable to CBA (our payment administrator).
3. Mail the completed Group Summary Form, accompanying Employee Applications and check to NDHS at 37 Cannon Range Road, Suite 200, Milmay, NJ 08340 no later than 7 business days prior to the requested eligibility date.

Note: List bill groups who fall below 5 members must transition to a monthly ACH or Credit Card withdrawal.



DO NOT ENTER GROUP ENROLLMENTS ON WWW.HEALTHFLEXRX.COM
Mail or Fax all Group Enrollments to NDHS as directed above.

Direct all inquiries/questions regarding group enrollments to April Shaw at NDHS via email aprilshaw@comcast.net or phone 1-800-687-3995 ext. 102.



EMPLOYER SUMMARY FORM

Requested Eligibility Date: _____

Business Name: _____ Business Address: _____ City: _____ State: _____ Zip: _____ Phone: () _____ Fax: () _____ Email Address: _____ EIN/Federal Tax ID: _____	_____ Contact Name for billing / eligibility _____ Title _____ Direct number or extension
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Please list each Primary Member below.

Primary Member Name	Plan Type (I/F)*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

*Plan Type – I (Individual), F (Family)

Enter the number of employees to be enrolled (enrollment forms attached), and the total monthly payment amount.

	#Enrolled	Amount
Individual at \$19.95 per month		\$
Family at \$29.95 per month		\$
Total for enrolling employees		\$
One time Set-up fee of \$2.50 per employee		\$
First month total, due now		\$
Make checks payable to CBA		

Payment Options

1. Monthly ACH withdrawal:

- Include a voided check with the completed Group Summary Form and Employee Applications when submitted.

Account Number _____ 9 Digit Routing Number _____

2. Monthly Credit Card withdrawal:

- Please enter your card information here:
Credit Card Type: Visa® MasterCard AMEX Discover

Account Number: _____

Account Holders Name: _____

Expiration Date: _____ Verification Code: _____
(3 digits on the right side of your signature line)

THIS SUMMARY FORM AND ACCOMPANYING EMPLOYEE ENROLLMENT FORMS MUST BE RECEIVED BY NDHS NO LATER THAN 7 BUSINESS DAYS PRIOR TO THE REQUESTED ELIGIBILITY DATE.

I acknowledge the following terms for billing: The first month's membership fees, the one-time enrollment fees, and the completed employee applications must accompany this form. **List Bill;** if your payments are made by company check you agree to the following: An invoice will be emailed to the address above on the 26th of every month being due the last day of that month. If payment is not received, eligibility shall be terminated. **Automatic Bill;** if your payments are made by ACH, electronic debit or Credit Card you agree to the following: Recurring payments will be drafted monthly within two days of the last day of the month. A confirmation of this payment will be emailed to the address above. **Eligibility:** Eligibility changes (additions and terminations) shall be submitted by the 25th of the month to be effective on the 1st of the following month. Eligibility changes received after the 25th will not be effective until the 1st of the next month (approx. 35 days). **Returned items, including electronic payments, are subject to a \$25 handling fee. I understand HealthFlex Rx is not insurance.**

For eligibility terms please note: "Following" = next calendar month and "Next" = second calendar month. Example: If this is January then the following is February and the next is March.

Authorized Signature: _____ Date: ____/____/____

Name: (Please Print): _____ Title: _____

Marketer Representative Name: _____ AGI#: _____