Retiree Dental Choice 1 Enrollment Application

Agent #: _____

For Office Use Only

Effective Date:

Retirement Date:

Type of Enrollment:

■ New ☐ Change ☐ Reinstatement

Complete this section to apply for Member coverage

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number _____

Date of Birth: _____ Social Security #: _____

Complete this section to add Spouse and/or Dependent coverage

SPOUSE

Name: _____ Relationship to Member: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Social Security #: _____

DEPENDENT

Name: _____ Relationship to Member: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Social Security #: _____

Complete this section for All persons to be covered

Insured name	**Dental Office Selction** (6 digit code found on provider list) *Primary Selection*	*Secondary Selection*

Sign and Date

I accept the coverage/insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverage as indicated on this form.

I authorize payment of dental benefits to the provider of dental care.

I authorize any participating dental office to release dental records and billing information concerning me or my dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Health and Connecticut General Life Insurance Company to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. CIGNA Dental Health and Connecticut General Life Insurance Company do not require tests in any state as a condition of obtaining dental coverage.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of insurance fraud. (In Florida, this is a felony of the third degree).

I am a CSEA Retiree Member and hereby enroll in the CSEA Retiree Dental Choice 1 Program. I have read and accept the provisions above.

Signature: _____ **Date**: _____

Sign Here to Apply for CHOICE ONE

→ → **Must turn over to select payment method** → →

Voluntary Dental Program

Choice 1

Call 1.800.367.1037
Select Automated Menu Option #3
Find a dentist, verify they are accepting new patients,
and that they take the Cigna HMO plan.
www.cigna.com/web/public/hcpdirectory

CHOICE 1 MONTHLY RATES *All States*
Rates effective through December 31st, 2020

Member: $30.99

Member + 1 (spouse or child): $58.25

Family: $101.64

CHOICE 1 Down Payment Amounts for EFT or Pension Deduction

Member: $61.98

Member + 1 (spouse or child): $116.50

Family: $203.28

CHOICE 1 Down Payment Amounts for Direct Bill

Quarterly: Submit 3 months premium

Semi-Annual: Submit 6 months premium

Annual: Submit 12 months premium

CSEA Retiree Insurance Program
c/o Pearl Insurance | cseainsurance.com
1.888.507.1368 | *Enjoy Life. We Got This.*

CSEA Retiree Payment Options

You have 3 easy payment options as described below. Please note that to begin coverage, and with all payment options, we first require a payment with your signed and dated application(s). Specific payment requirements for each payment option are listed below.

OPTION 1: Electronic Funds Transfer (EFT)

With Electronic Funds Transfer (EFT), you authorize your bank or financial institution to automatically deduct your monthly insurance premiums from your checking account. Paying your premiums by EFT is easy and convenient…save time writing checks and the postage cost to mail them…and there's no extra fee for installment payments!

Automatic withdrawals

- All withdrawals authorized will appear on your bank statement as "Pearl Insurance."
- Withdrawals will be taken on the first business day of the month.
- If your account does not have enough money, your bank may charge you for insufficient funds when we try to withdraw your payment. We will try to withdraw the money up to two times. If we are unsuccessful, we will notify you by mail of the missed payment and you may risk cancellation of the payment plan.
- If you cancel your policy before the current month's withdrawal date, we will notify you by mail of any balance due.

PAYMENT REQUIREMENT: First 2 months premium for initial payment

OPTION 2: Direct Bill Sent to Your Home

You may opt to have a bill sent to your home based on the billing cycle you choose: Quarterly, Semi-Annually or Annually.

PAYMENT REQUIREMENT: Your initial premium payment will depend on the billing cycle you choose.

- For quarterly billing, please include 3 months premium.
- For semi-annual billing, please include 6 months premium.
- For annual billing, please include 12 months premium.

OPTION 3: Pension Deduction

You may opt to have your payments deducted from your New York State pension. **Please note that if you are a new retiree not yet receiving a pension, you will be placed on direct bill for the first 5 months until pension deductions can begin.**

PAYMENT REQUIREMENT: First 2 months premium for initial payment

Effective Date Rules:
Application received before 15th of month, Effective date is the 1st of following month.
Application received after 15th of month, Effective date is the 1st of the consecutive month.

POLICYHOLDER INFORMATION *Please print*

CSEA Retiree Insurance Program
c/o Pearl Insurance | cseainsurance.com
1.888.507.1368 | *Enjoy Life. We Got This.*

Insured's Name (First, MI, Last Name)

Home Address (Street, City, State, Zip)

Daytime Phone | Email Address

OPTION 1: Electronic Funds Transfer (EFT) If you choose to have your monthly premium deducted from your bank account, please complete below with your banking information and **include a check for your initial premium payment** - made payable to Pearl Insurance.

Bank Routing Number | Bank Account Number

Bank Name | Bank Account Owner's Name *(if different than Policyholder)*

AUTHORIZATION & SIGNATURE: I certify that I am the owner and/or authorized signer for this bank account, and I authorize Pearl Insurance NY ("Pearl Insurance") to make electronic debit entries for payment of insurance premiums for my policy(ies) from this account. The entries shall constitute my receipt for the transactions(s). I also understand that if corrections of the entry are necessary, it may involve an adjustment to my account. I recognize that this authorization allows Pearl Insurance to adjust my scheduled deductions to reflect any premium changes. I understand that it is my responsibility to make sure that there are sufficient funds in this account at the monthly withdrawal date. I also understand that the policy(ies) may cancel or expire if there are insufficient funds in the account, pursuant to the terms of the policy(ies). This authorization is to remain in effect until Pearl Insurance receives written notification of its termination and has sufficient time to act on it.

Bank Account Owner's Signature | Date

Option 2: Direct Bill If you choose to have your bill sent to your home, please select your billing cycle and **include a check for your initial premium payment** - made payable to Pearl Insurance. **Your initial premium payment will depend on the billing cycle you choose.**

CHECK ONE: ☐ Quarterly Bill ☐ Semi-Annual Bill ☐ Annual Bill

Member Signature | Date

Option 3: Pension Deduction If you choose to have your monthly premium deducted from your New York State Pension check, **please include a check for the first 2 months premium** - made payable to Pearl Insurance (your Pension Deductions will begin after the first 2 months) and sign the Pension Deduction Authorization below.

Pension Deduction Authorization: Pursuant to Section 110-c and 410c of the Retirement and Social Security Law, I hereby authorize deductions to be made from my monthly allowance from the New York State and Local Employees Retirement Systems in the amount necessary to cover membership dues and insurance on my behalf to CSEA, Local 1000, AFSCME, AFL-CIO. Authorization is also given to make any changes the Union certifies to the Retirement System as necessary in the amount of such dues and insurances. I, the undersigned, do hereby authorize you to deduct from my monthly allowance the amount of $3.00 for payment of dues, or any amount as may be certified to you by the Union as my dues and or insurance. I understand that CSEA, Local 1000, AFSCME, AFL-CIO is my agent and all request to begin, modify, or revoke deductions must be submitted through the Union. This authorization shall remain in effect until revoked by me by written notice through the Union or until otherwise revoked pursuant to law.

Pensioner Signature | Date

Retirement Number (Required number printed on pension check) | Pensioner SSN#