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** → →

Select your Payment Method from the following 3 options:

☐ Option 1: Automatic Pension Deduction

Note: You must currently be receiving a New York State pension to select this payment method.

If you choose to have your monthly premium deducted from your New York State Pension check, please:

1. Include a check for the first 2 months premium - made payable to Pearl Insurance.
   (your Pension Deductions will begin after the first 2 months)
   - *2 Months Member:* $59.60
   - *2 Months Member + 1 :* $112.04
     (Spouse or child)
   - *2 Months Family:* $195.48
2. 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.

Signature: _____ **Date**: _____

☐ Option 2: Automatic Checking Account Withdrawal

If you choose to have your monthly premium deducted from your checking account, please:

1. Include a check for the first 2 months premium - made payable to Pearl Insurance.
   (your Automatic Checking Account Withdrawals will begin after the first 2 months)
   - *2 Months Member:* $59.60
   - *2 Months Member + 1 :* $112.04
     (Spouse or child)
   - *2 Months Family:* $195.48
2. Sign the Checking Account Deduction Authorization below

Checking Account Deduction Authorization

I (we) hereby request and authorize you to effect a transfer each month on the account (name and number shown on check) for the payment of insurance premiums due during such month for the coverage that I have applied for. This authorization is to remain in effect until it is revoked by either of us in writing. Until you receive such written notice of revocation, I (we) agree that you shall be fully protected in processing such transfers. I (we) agree that if any such transfer is dishonored, the payment for insurance will be considered to be in default pursuant to the terms of the policy. This authorization shall be effective as of the date stated below. It is agreed that Pearl Insurance will automatically withdraw from my account the amount necessary to pay the monthly premium for the coverage(s) that I have applied for.

Signature: _____ **Date:** _____

☐ Option 3: Direct Bill Sent to Your Home

1. **Select your billing cycle (check one):**

   ☐ *Quarterly* ☐ *Semi-Annual* ☐ *Annual*

2. **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. Below is an illustration of the required initial premium payment based on your billing cycle.

Quarterly	*Semi-Annual*	*Annual*
Submit 3 months premium	Submit 6 months premium	Submit 12 months premium