NYSCOPBA Retiree Dental Program Enrollment Form

Election form must be received 3/7/22

IMPORTANT

Participation in the NYSCOPBA Retiree Chapter Voluntary Dental Plan is an annual election. Your coverage will be effective on April 1, 2022. April 1st is the dental plan anniversary date and you cannot cancel or opt-out of coverage until April 1, 2023. Each year prior to April 1st, you will receive a notice to advise you that your 12-month participation is upcoming. Only at that time, will you be able to cancel coverage or switch plans.

EmblemHealth, Inc. insurance plans are underwritten by Group Health Incorporated (GHI), HIP Health Plan of New York (HIP) and HIP Insurance Company of New York.

PLEASE PRINT CLEARLY AND MARK CAREFULLY.

ABOUT YOU

First, MI, Last Name:	
Social Security Number: ____ ____ ____-____ ____-____ ____ ____ ____	
Address:	
City/State/Zip:	Phone: ( ) _____-_____
Date of Birth: (mm-dd-yy) _____-_____-_____ Gender: M ☐ F ☐	Email Address:
Date of retirement: _____-_____-_____	NYS Retirement Number: _____

Do you have any other dental insurance? (Including COBRA or DIRECT PAY through NYS ☐ yes ☐ no)
If so, name of other dental carrier: _____

DENTAL COVERAGE

You must be enrolled to cover your dependents. Check only one box.

		Member Only	Member and 1 Dependent (Spouse/Domestic Partner or Child)	Member, Spouse/Domestic Partner and Dependent Child(ren)
Option 1	Basic Plan	☐ $17.17	☐ $32.52	☐ $53.29
Option 2	Enhanced Plan	☐ $40.86	☐ $79.98	☐ $138.96

ABOUT YOUR FAMILY

Please include the names of the dependents you wish to enroll for coverage.Dependent Children are covered to the end of the year in which they turn age 26.

☐ Spouse or ☐ Domestic Partner _____ (First, MI, Last Name)		Gender M ☐ F ☐	Spouse Social Security # _____ Date of Birth (mm-dd-yy) _____-_____-_____	
Child/Dependent 1:	☐ Add	Gender M ☐ F ☐	Date of Birth (mm-dd-yy) ___-___-___	Dependent SS # _____ Check if any apply: ☐ Student (post high school) ☐ Disabled
Child/Dependent 2:	☐ Add	Gender M ☐ F ☐	Date of Birth (mm-dd-yy) ___-___-___	Dependent SS # _____ Check if any apply: ☐ Student (post high school) ☐ Disabled
Child/Dependent 3:	☐ Add	Gender M ☐ F ☐	Date of Birth (mm-dd-yy) ___-___-___	Dependent SS # _____ Check if any apply: ☐ Student (post high school) ☐ Disabled
Child/Dependent 4:	☐ Add	Gender M ☐ F ☐	Date of Birth (mm-dd-yy) ___-___-___	Dependent SS # _____ Check if any apply: ☐ Student (post high school) ☐ Disabled

Please see reverse side for required signature.

SIGNATURE

- I understand that my dependent(s) cannot be enrolled for coverage, if I am not enrolled for that coverage.
- Plan design limitations and exclusions may apply. State limitations may apply.
- Effective date of coverage is **April 1, 2022**
- I hereby apply for the group benefit(s) that I have chosen.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree the NYS Retirement System may deduct premiums from my pension check or add premiums, if they are required for the coverages I have chosen.
- I state that the information provided is true and correct to the best of my knowledge.

The state in which you reside may have a specific state fraud warning. Please refer to the Fraud Warning Statement below.

The laws of New York require the following statement appear. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Member X _____ Date_____

Please return completed application to:

Norvest Financial Services, Inc.
930 Albany Shaker Road
Latham, NY 12110

NORVEST
Financial Services, Inc.

For questions or additional information, please contact our Administrator,
Norvest Financial Services, Inc. at 1-888-869-8252 • www.norvest.net