NYSCOPBA Retiree Dental Program
Annual Election Form

Plan Anniversary Date 4/1/22 • Election form must be received by 3/7/22

This plan is underwritten by the EmblemHealth Dental - Group Health Incorporated (GHI)

PLEASE PRINT CLEARLY AND MARK CAREFULLY.

PLEASE SELECT ONE OF THE FOLLOWING

☐ I choose to cancel my current coverage effective 4/1/22
☐ I choose to switch from the Basic Plan to the Enhanced Plan
☐ I choose to remove the following Dependent(s) _____

Note: If you plan to include your dependents at this time, please check the appropriate box and complete the following about your family:

☐ Member and 1 Dependent (Spouse/Domestic Partner or Child)
☐ Member, Spouse/Domestic Partner and Dependent Child(ren)

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: _____

ABOUT YOUR FAMILY

Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exemption. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

☐ 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_____

12-Month Plan: Participation in the NYSCOPBA Retiree Dental Plan is an annual election on April 1st of each year. Your initial coverage will be effective on the first day of the month when the dental premium is deducted from your monthly retirement check. You will have the opportunity to change your election or cancel coverage only on April 1st of each year. Once your election is made, you will be insured until April 1st of the following year.

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