NYSCOPBA Retiree Dental Program Enrollment Form

Scan to enroll online!

COMPLETED FORM MUST BE RECEIVED BY MARCH 6, 2025 FOR COVERAGE TO BE EFFECTIVE APRIL 1, 2025

IMPORTANT

Participation in the NYSCOPBA Retiree Voluntary Dental Plan is an annual election. April 1st is the dental plan anniversary date and you cannot cancel or opt-out of coverage until April 1, 2026. Each year prior to April 1st, you will receive a notice and only at that time will you be able to cancel coverage or transfer to the Enhanced Plan.

Guardian Insurance Company is a Mutual Insurance Company owned by its Policyholders headquartered in New York for 160 years. We provide a wide range of Group and Individual insurance products to the marketplace. Our Group Dental Insurance coverage in all 50 states with a Discounted PPO with over 140,000 providers to select in network services from. Guardian provides Dental Insurance for over 25 million members in 2024 . Guardian has very strong ratings A++ from A.M. Best and AA+ from Standard and Poor's

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: **R-**

Have you had dental coverage in the past 60 days (including COBRA or Direct Pay through NYS): ☐ Yes ☐ No
If so, name and telephone number of dental carrier: _____
If no prior dental coverage, you may **ONLY** enroll in the Basic Plan this year. At the next annual enrollment you may transfer to the Enhanced Plan if you choose.

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	☐ $19.53	☐ $37.40	☐ $61.13
Option 2	Enhanced Plan	☐ $35.65	☐ $67.03	☐ $102.69

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/DP 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 disabled: ☐ Disabled
Child/Dependent 2:	☐ Add	Gender M☐ F☐	Date of Birth (mm-dd-yy) ____-____-____	Dependent SS#_____ Check if disabled: ☐ Disabled
Child/Dependent 3:	☐ Add	Gender M☐ F☐	Date of Birth (mm-dd-yy) ____-____-____	Dependent SS#_____ Check if disabled: ☐ Disabled
Child/Dependent 4:	☐ Add	Gender M☐ F☐	Date of Birth (mm-dd-yy) ____-____-____	Dependent SS#_____ Check if disabled: ☐ 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.
- **I understand once I enroll in the Enhanced Plan I cannot transfer to the Basic Plan.**
- Plan design limitations and exclusions may apply. State limitations may apply.
- Effective date of coverage is **April 1, 2025.**
- 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 elected on this Enrollment Form.
- I acknowledge and consent to receiving electronic copies of Guardian coverage related documents, in lieu of paper copies, to the extent permitted by applicable law.
- 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_____

Guardian®

Please return completed application to:

Norvest Financial Services, Inc.
930 Albany Shaker Road
Latham, NY 12110
or
Scan the QR Code below to enroll online
at nyscopbaenroll.com

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