## DECLARATION SECTION

Each person signing below declares that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by SafeGuard to determine his or her eligibility.

**For Changes Requested After Initial Enrollment Period Expires.** I understand that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

Primary Language:_____ Please note any communication impairment:_____

Authorization to release dental records. I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all dental records which pertain to me or any member of my family, maintained by my chosen Selected General Dentist and/or Specialty Care Dentist, to SafeGuard and/or any designated agent or representative for the purposes of dental treatment, care and for SafeGuard's quality assessment and utilization reviews, which will be kept strictly confidential. The authorization shall remain valid for the term of this coverage.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for benefits or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Signature(s):** The Member/Employee must sign in all cases. Each person signing below acknowledges that he or she has read and understands the statements and declarations made in this enrollment form.

X_____ _____ _____
Member/Employee Signature | Print Name | Date (Mo./Day/Yr.)

## SELECT PAYMENT OPTION

☐ **Annual Check** – Enclosed is my annual payment made payable to: Forrest T. Jones & Company
☐ **Monthly Electronic Funds Transfer (EFT)** - If you select this option be sure to include a check for your first monthly premium payment as well as a voided check as explained below.

**I request and authorize Forrest T. Jones & Company to make monthly withdrawals against the account specified on the attached voided check** and bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this CSEA Dental Insurance Plan. (Enclose a VOIDED check.)

X_____ _____
Authorized Signature for Automatic Deductions | Date (Mo./Day/Yr.)

I authorize MetLife or Safeguard or any participating dental office to release dental records for myself or any covered family member to any MetLife company for plan administration purposes. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge or better.

I understand that I must be a member in good standing at CSEA in order to apply for and retain this coverage and that verification of my membership is hereby authorized.

X_____ _____ _____
Member Signature | Membership # | Date (Mo./Day/Yr.)

After completion, sign and date the form where indicated. Make a copy for your records and return to:
Forrest T. Jones & Company, ATTN: Admin-FP, 3130 Broadway Blvd., Kansas City, MO 64111
Or Fax to: 816-751-6092. For questions, please call 800-821-7303.

### About Our Role and Compensation

In this transaction, United Insurance Partners (UIP) is acting as the exclusive insurance agent and Forrest T. Jones & Company (FTJ) is acting as the program administrator for MetLife (insurer) for this type of coverage and not as your insurance agent. As the agent and the administrator for the insurer, UIP and FTJ may provide these services: billing, marketing, customer administration, and claim servicing and communications. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the premiums charged by the insurers. We may also receive additional compensation that is based on volume, profitability, and other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. If you would like additional information about our compensation, please refer to: ***www.cseabenefits.com/disclosure***.

### Fraud Warning

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 therreto commits a fraudulent act, which is a crime and subjects such person to ciminal and civil penalties.

UIP United Insurance Partners
CSEA MEMBER BENEFITS INSURANCE PROVIDER

**Program Agent:**
United Insurance Partners,
UIP Insurance Services LLC
CA Ins. License #0252636
(833) 426-2732

**Program Administered by:**
Forrest T. Jones & Company
CA Ins. License #0592939
(888) 316-8785 or (800) 821-7303

8650_0619 AEU

MetLife

# Dental Plans for Active and Retired CSEA Members

## Dental HMO Application

Member only **savings**

I'm CSEA In!
AFL-CIO

CSEA is pleased to sponsor two dental plans from MetLife. These plans are designed for our members who are not eligible for group coverage through their district or who are retired.

## MetLife PPO

The MetLife PPO offers the advantages of a fee-for-service program, with comprehensive benefits and user-friendly claims administration. You achieve the broadest coverage with the lowest out-of-pocket costs when using one of 18,975 providers (dentists) in 43,462 locations in California. An initial waiting period applies for major services. Coverage is available in most states. Find a participating dentist today at www.metlife.com.

## MET100 HMO/MANAGED CARE

This option is a dental HMO product featuring cost-effective and comprehensive benefits when using one of our 3,678 providers (dentists) in 9,291 locations in California. Participants receive a schedule of benefits and copayments, so they know in advance their financial responsibility. Coverage is not available in all states.

Continuing CSEA members and newly eligible members may enroll in these plans. A newly eligible member is a member who has been laid-off within the last 60 days, new CSEA members and newly retired CSEA members.

Note: Members initially enrolling in the MetLife PPO plan will have the 12-month waiting period for major procedures even if they are transferring from another Metlife plan or other provider.

| DUAL CHOICE DENTAL PLAN OPTIONS FOR CSEA MEMBERS | METLIFE PPO (DENTAL PPO) Covered benefit percentages when visiting any licensed dentist | | MET100 HMO/ MANAGED CARE Copayment when visiting network dentist (no coverage outside of California; copayment range depends on procedure) |
|---|---|---|---|
| | PPO dentist | Non-PPO dentist | |
| **Benefits (1st year)** | | | |
| Diagnostic/preventative | 100% | 50/50* | no cost |
| Basic (sealants, simple restoration, extraction) | 80/20 | 50/50* | $2 - $75 |
| **Additional Benefits (2nd year*)** | | | |
| Basic – misc. restorations | 80/20 | 50/50* | $0 - $25 |
| Basic – oral surgery | 80/20 | 50/50* | no cost - $75 |
| Basic – Endodontics | 80/20 | 50/50* | no cost - $95 |
| *Covered only following 12 months of continuous enrollment | | | |
| **Basic – periodontics** | 50/50 | 50/50* | $15 - $260 |
| Crowns, cast restorations | 50/50 | 50/50* | no cost - $100 |
| Prosthodontics Orthodontics | 50/50 | 50/50* | $10 - $125 |
| (adult and children) | 50/50 | 50/50* | $1,450 children/ $1,450 adults |
| **Covered only following 12 months of continuous enrollment | | | |
| **Deductible** | $50 | $50 | None |
| Per patient per calendar year (This program has no deductible for diagnostic and preventative benefits regardless of whether treatment is provided by a PPO dentist or a non-PPO dentist.) | | | |
| **Program Maximum** | | | |
| Orthodontic Maximum | $1,000 | $1,000 | N/A |

*50% of the MetLife Non-PPO dentist negotiated rate.

| MetLife PPO Plan | Monthly Rates |
|---|---|
| Member Only | $ 49.52 |
| Member + One | $ 89.05 |
| Member + Family | $159.40 |

| Met100 HMO/Managed Care | Monthly Rates |
|---|---|
| Member Only | $23.85 |
| Member + Family | $59.62 |

**Visit *cseabenefits.com* for more details on your Dental benefits and for exclusive savings and promotions for CSEA members or call us today at (833) 426-2732.**

## ENROLLMENT FORM FOR GROUP DHMO BENEFITS

MetLife

*Benefits provided by*
**SafeGuard Health Plans, Inc., a MetLife company**
*5 Park Place, Suite 1850, Irvine, CA 92614-2533*

**Please print clearly when completing the Enrollment Form and return it to your Benefits Coordinator, Choose a Selected General Dental Office (facility number) of your choice for each eligible family member from the Directory of Participating Dentists. Failure to do so may result in delays in receiving dental care. If your first provider facility selection is not available, SafeGuard will process your second selection.**

### SECTION TO BE COMPLETED BY BENEFITS COORDINATOR

| Name of Policyholder (Please Print) | Group No. | Division/Sub Code | Class/Branch Code |
|---|---|---|---|
| **California School Employees Association** | **220355** | | |
| Dept Code | Coverage Effective Date (MM/DD/YYYY) | | |

### SECTION TO BE COMPLETED BY MEMBER/EMPLOYEE

| Name (First, Middle, Last) | Social Security No. | ☐ Male ☐ Female | ☐ Single ☐ Married |
|---|---|---|---|
| Address (Street, City, State, Zip Code) | | Date of Birth (Mo./Day/Yr.) | |
| ☐ Employee/Active Members ☐ Retired | Job Title: | | |
| ☐ New Enrollment ☐ Change in Enrollment | | | |
| Email Address: | Phone Number (include area code): | | |

**SELECT A SELECTED GENERAL DENTAL OFFICE:** MUST BE COMPLETED TO ENROLL IN PLAN

Failure to select a Selected General Dental Office may result in delays in receiving dental benefits. If your first facility selection is not available, we will process your second selection. Facility numbers are found next to each Selected General Dental Office's name in the Directory of Participating Dentists.

**Facility Number - 1st Choice:**

**Facility Number - 2nd Choice:**

**COVERAGE REQUEST DATA:**

I have received and read a copy of the group's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.

**I request the following coverage:**

**Member/Employee Coverage**
☐ Dental

**Spouse/Domestic Partner Coverage**
☐ Dental

**Dependent Child Coverage**
☐ Dental

**If applying for Dependent coverage (Spouse/Domestic Partner and Child), complete section below:**

Choose a Selected General Dental Office (facility number) of your choice for each eligible family member from the Directory of Participating Dentists.

Number of Dependents (including Spouse/Domestic Partner):

| | Name (First, Middle, Last) | Date of Birth (MM/DD/YYYY) | Sex (M/F) | Facility 1st | Facility 2nd |
|---|---|---|---|---|---|
| Spouse /Domestic Partner: | | | | | |
| Child(ren): | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Find a participating Dentist in the Dental HMO/Managed Care plan.

The Dental HMO Met 100/Managed Care plan's network includes both private practice dentists and those who are in a clinic environment. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online Find a Dentist directory.

**Step 1:** Go to metlife.com

**Step 2:** Select "I want to find a MetLife"
*Click "Dentist" and enter your ZIP Code, and select the Dental HMO Met 100/Managed Care network.*

**Step 3:** Enter the Plan Name
*The plan name is located in your Schedule of Benefits.*