DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
4. I have read the applicable Fraud Warning(s) provided in this enrollment form.

X _____ Member/Employee Signature

_____ Print Name

_____ Date (Mo./Day/Yr.)

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;
GEFO9-1
DEC appliest to residents of North Dakota and Utah)

California School Employees Association
EF-ST200M-CA (10/19)

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

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MetLife

Dental Plans for CSEA Members

WITH PRIOR COVERAGE WITHIN 30 DAYS OF ENROLLING*

Dental PPO Application

$1500 ANNUAL MAXIMUM

Member only savings

I'm CSEA In!

*Certain waiting periods will be waived with proof of prior coverage.

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 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.)	$50	$50	None
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	$ 51.01
Member + One	$ 91.72
Member + Family	$164.18

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 • CHANGE FORM
For 0919 Dental PPO plan - when prior coverage ends

MetLife Metropolitan Life Insurance Company
New York, NY 10166

GROUP INFORMATION *(TO BE COMPLETED BY THE RECORDKEEPER)*

Name of Policyholder (Please Print)			Group Customer #	Report #	Sub Code
California School Employees Association			220355	220355	
Report #	Sub Code	Branch	Coverage Effective Date (MM/DD/YYYY)		
220355	0003				

YOUR ENROLLMENT INFORMATION *(TO BE COMPLETED BY THE MEMBER)*

Name (First, Middle, Last)		Social Security #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	Date Prior Coverage Ended (MM/DD/YYYY)	

I have read my enrollment materials and I request coverage for the benefits for which I am or may be eligible. I understand that contributions are required for the benefits I select below.

The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

Dental Insurance

☐ PPO Options

Select your level of coverage:

☐ Member Only
☐ Member + One Dependent (Spouse/Domestic Partner[1] or Child)
☐ Member + Two or More Dependents (Spouse/Domestic Partner[1] and Children)

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

[1] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner if you and your Domestic Partner have either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to such a relationship.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;
GEFO2-1
ADM
DEC appliest to residents of North Dakota and Utah)

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.