

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;
GEF09-1
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 thereto commits a fraudulent act, which is a crime and subjects such person to criminal 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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Dental Plans for
CSEA Members

WITH PRIOR COVERAGE WITHIN
30 DAYS OF ENROLLING*

Dental PPO Application



Member only
savings



*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.



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.

DUAL CHOICE DENTAL PLAN OPTIONS FOR CSEA MEMBERS	METLIFE PPO (DENTAL PPO)		MET100 HMO/MANAGED CARE
	Covered benefit percentages when visiting any licensed dentist		
	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 (adult and children)	50/50	50/50*	\$10 - \$125
**Covered only following 12 months of continuous enrollment	50/50	50/50*	\$1,450 children/ \$1,450 adults
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

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



GROUP INFORMATION (TO BE COMPLETED BY THE RECORDKEEPER)

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

YOUR ENROLLMENT INFORMATION (TO BE COMPLETED BY THE MEMBER)

Name (First, Middle, Last)		Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> 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 Partner¹ or Child)

☐ Member + Two or More Dependents (Spouse/Domestic Partner¹ 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)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
		<input type="checkbox"/> Male	<input type="checkbox"/> Female
		<input type="checkbox"/> Male	<input type="checkbox"/> Female
		<input type="checkbox"/> Male	<input type="checkbox"/> 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
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