

ENROLLMENT FORM FOR NCRGEA - METLIFE GROUP DENTAL COVERAGE

Group Name: NORTH CAROLINA RETIRED GOVERNMENTAL EMPLOYEES' ASSOCIATION Group Number: 104057-110108

(TO BE COMPLETED BY NCRGEA MEMBER - PLEASE PRINT LEGIBLY)

Directions:

1. Complete all responses. Incomplete forms cannot be processed.
2. This form must be signed to be processed.
3. After the first premium deduction is made, a dental insurance membership card and a benefits booklet will be mailed to you.

Name: _____
(Last) (First) (Middle Initial)

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Date of Birth (Mo/Day/Yr): _____

Home Telephone Number (Include Area Code): _____

Alternate Telephone Number (Cell or Work): _____

Email address: _____

**DO NOT WRITE IN THIS AREA
FOR OFFICE USE ONLY
(TO BE COMPLETED BY NCRGEA)**

Based on the coverage chosen,
the dental premium deduction
will be \$ _____ PER MONTH

The first premium deduction will
be made on
_____ 25, 201__

If the dues are not currently
being deducted, the first dues
deduction will be made on
_____ 25, 201__
for a dues renewal date of
_____, 201__

Based on the yearly dues of
\$ _____, the dues deduction
will be \$ _____ PER MONTH

I wish to authorize monthly deduction of both my membership dues and deduction of dental premiums. If your NCRGEA membership dues have been paid for the current year, we will begin your dues deduction the month prior to your next scheduled renewal date. Dues are based on monthly income (see enclosed membership enrollment card for the scale).

My annual dues are: _____ \$10 (\$.83 monthly) _____ \$15 (\$1.25 monthly) _____ \$20 (\$1.67 monthly)

PLEASE MARK ONE BOX BELOW TO SELECT THE DENTAL PLAN DESIRED:

- Member Only Coverage
- Member and Spouse
- Member and Dependent*
- Member and Spouse and Dependent*

- **Dependent: Children may be covered until their 26th birthday.**

IF SPOUSE AND/OR DEPENDENT COVERAGE HAS BEEN SELECTED, PLEASE FILL OUT THE FOLLOWING:

Spouse's Name: _____ Date of Birth: _____

Name of Child(ren): _____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

PAYROLL DEDUCTION AUTHORIZATION:

I received and read a copy of NCRGEA's current description of the group dental plan insured and administered by Metropolitan Life Insurance Company. If I qualify for payroll deduction, I agree to remain in the NCRGEA Dental Plan until December 31, 2013. By signing below, I declare that all the information given in this enrollment form is true and complete to the best of my knowledge and belief. I hereby authorize the North Carolina Retirement System to deduct from my retirement account both my membership dues and/or my monthly dental plan premium as I've indicated above. This authorization applies to such coverage until I rescind it in writing.

Signature:

Member's Signature _____

Date (Mo/Day/Yr) _____

If you have questions about this plan and/or the plan's coverage, please call toll free at 1-800-356-1190. Mail the completed enrollment form to:

NCRGEA, PO Box 10561, Raleigh, NC 27605-0561