Enrollment and Change Form for NCRGEA
The Standard Insurance Company Group Dental Coverage

Group Name: **NORTH CAROLINA RETIRED GOVERNMENTAL EMPLOYEES' ASSOCIATION** Group Number: **160-758158**

Please complete all information to enroll or make changes.

If you are currently enrolled in the NCRGEA dental plan and would like to continue at the same level of benefits, **no action is required.** You will automatically be enrolled in the High Plan.

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

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security Number: _____

Date of Birth: **Month** _____ **Day** _____ **Year** _____

Home Telephone Number (Include Area Code): _____

Cell Phone Number (Include Area Code): _____

Email Address: _____

To ENROLL or CHANGE plan: Select:	☐ **High Plan**	☐ **Low Plan**
	Monthly rates	
☐ Member Only Coverage	$47.76	$36.12
☐ Member and Child(ren)*	$74.40	$70.56
☐ Member and Associate **	$95.52	$72.24
☐ Member and Spouse	$107.48	$86.56
☐ Member and Spouse and Children*	$133.68	$119.96

* (Children may be covered until their 26th birthday, unless disabled)

** (Associate is a dues paying spouse of an active NCRGEA Member)

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 begin on
_____25, 20_____

If the dues are not currently being deducted, the first dues deduction will be made on
_____25, 20_____
for a dues renewal date of
_____, 20_____

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

To ADD or DROP dependents, or terminate coverage, fill out this section and circle ADD or DROP:

Spouse Name: _____ M / F Date of Birth_____ ADD/DROP

Child Name: _____ M / F Date of Birth_____ ADD/DROP

Child Name: _____ M / F Date of Birth_____ ADD/DROP

Child Name: _____ M / F Date of Birth_____ ADD/DROP

Changes in Dependent Coverage will be effective: _____

☐ **Terminate my dental coverage effective:** _____

Signature: _____ **Date:** _____

PAYROLL DEDUCTION AUTHORIZATION:

I received and read a copy of the NCRGEA's current description of the group dental plan insured and administered by The Standard Insurance Company. If I qualify for payroll deduction, I agree to remain in the NCRGEA Dental Plan until December 31, 2020. 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 check my membership dues and/or my monthly dental plan premium indicated above. When NCRGEA membership dues have been paid for the current year, my dues deduction will begin the month before the scheduled renewal date.** This authorization applies to such coverage until I rescind it in writing.

Signature: _____ **Date:** _____

Tear Along Dotted Line