PASR
Pennsylvania Association of School Retirees

Please see other side on how to apply…

Dental & Vision Enrollment Form

PLEASE PRINT CLEARLY

PASR MEMBER - APPLICANT

Social Security Number (RQD)	*Last Name*	*First*	*M. I.*

Street Address	*Telephone* ( )

City	*State*	*Zip*	*Sex* ❑ *M* ❑ *F*	*Birth Date (Mo/Day/Yr)*

Email

FAMILY MEMBERS - DEPENDENTS

	Social Security #	*Last Name*	*First*	*M.I.*	*Sex*	*Birth Date (Mo/Day/Yr)*
Spouse					❑ *M* ❑ *F*	
Child					❑ *M* ❑ *F*	

DENTAL COVERAGE DESIRED & ANNUAL PAYMENTS (Please ✔ one)

Standard Plan

❑ Individual (Applicant Only) $516	❑ Two-Party (Applicant Plus One) $972	❑ Family (Applicant Plus Two or More) $1,488

Premium Plan (Participation term 36 months)

❑ Individual (Applicant Only) $864	❑ Two-Party (Applicant Plus One) $1,596	❑ Family (Applicant Plus Two or More) $2,520

VISION COVERAGE DESIRED & ANNUAL PAYMENTS (Please ✔ one)

Standard Plan

❑ Individual (Applicant Only) $70	❑ Two-Party (Applicant Plus One) $125	❑ Family (Applicant Plus Two or More) $175

Enhanced Plan

❑ Individual (Applicant Only) $80	❑ Two-Party (Applicant Plus One) $140	❑ Family (Applicant Plus Two or More) $210

PAYMENT METHOD

❑ ***Enclosed Check/Money Order***

Please send check payable to:
PASR
878 Century Drive
Mechanicsburg, PA 17055-4375

Credit Card #:

_____

*Exp. Date*_____ *Card Security Code* _____

*Signature*_____

❑ Visa ❑ MasterCard ❑ Discover ❑ AMEX

Important—Please read and sign below: *Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

I hereby apply for the coverage indicated and understand that the premium payment is for 12 months of coverage and is not refundable for any reason. If I do not renew my contract at the end of the 12 months, I cannot re-enroll for 36 months. I further understand that my enrollment is subject to receipt of payment in the correct amount. If a check is returned due to insufficient funds, a $20.00 fee will be charged. Either you or your spouse must be a PAID Member of PASR to enroll or renew your dental and/or vision coverage. Premiums are not refundable if cancelled due to non-payment of dues.

_____ _____

Applicant's Signature **Date**

HOW TO APPLY:

1. To apply for United Concordia Dental and/or Davis Vision by MetLife Vision coverage, complete this Application.

2. Check the Coverage you desire: **Individual; Two-Party** (member and spouse or member and child); or **Family** (member plus two or more dependents). Unmarried dependent children can be enrolled up to age 26, disabled dependents to any age. **If enrolling a disabled dependent age 26 or older please call (717) 697-7077 for a Dependent Certification form which must be completed and returned with your application.**

3. Participation in the premium dental plan is 36 months. After that period, you may elect standard plan at renewal. You will be billed each year.

4. Full annual premiums must be submitted for the type of coverage you choose. Payment in full options: check, money order, MasterCard, Visa, Discover, American Express credit card or Monthly Withdrawal from your checking account for dental only*. **Vision plan(s) must be paid in full.** If paying by credit card, please ensure that you complete the credit card information requested on the Application. Checks are to be made payable to "PASR." You may send one check/money order to cover the combined premiums if you choose both Dental and Vision coverage.
   *If you choose the "Monthly Withdrawal" option for the Dental coverage, **you are agreeing to pay the full annual premium.** Please complete the enclosed Authorization for Monthly Withdrawal Form. Monthly Withdrawal is only available for the Dental plans and cannot be applied to a credit card.

5. Mail the fully completed Application and your payment using the enclosed envelope to: Pennsylvania Association of School Retirees, 878 Century Drive, Mechanicsburg, PA 17055-4375.
   If your application(s) and payment are received at PASR by the 20th of the current month, the coverage will become effective the first of the following month. You will receive identification cards from Davis Vision by MetLife Vision and/or United Concordia Dental.

   IMPORTANT NOTICE:
   The Pennsylvania Association of School Retirees (PASR) endorses United Concordia Dental and Davis Vision by MetLife Vision Plans for PAID members of PASR and their eligible dependents.

   PASR routinely checks membership records to assure compliance. Either you or your spouse must be a PAID Member of PASR to enroll or renew your dental and/or vision coverage. Premiums are not refundable if cancelled due to non-payment of dues.

   Questions on the United Concordia Dental or Davis Vision by MetLife Vision plans can be directed to Pennsylvania Association of School Retirees at (717) 697-7077.