



Complete form and mail, fax or email to:  
 ATTN: NCRS  
 P.O. Box 727  
 Farmville, NC 27828  
 E-mail: info@pierceins.com

AUTHORIZED USE ONLY	
Policy Group Numbers:	708788
<input type="checkbox"/> PVRC 0001-0001	<input type="checkbox"/> PVRC 0002-0002
<input type="checkbox"/> PVRC 0003-0003	<input type="checkbox"/> PVRC 0004-0004
<input type="checkbox"/> PVRC 0005-0005	<input type="checkbox"/> PVRC 0006-0006
Dental Plan Code:	P3271
Effective Date:	

### DENTAL AND VISION ENROLLMENT FORM

SOCIAL SECURITY NUMBER:		DATE OF RETIREMENT / / (Month/Day/Year)		<input type="checkbox"/> ENROLL	<input type="checkbox"/> CANCEL	<input type="checkbox"/> CHANGE
LAST NAME:		FIRST NAME:	M.I.:	DATE OF CHANGE: / / (Month/Day/Year)		
ADDRESS:		CITY:		DATE OF BIRTH: / / (Month/Day/Year)		
STATE:	ZIP:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		EMAIL ADDRESS:		
TELEPHONE NUMBER: ( )						

<b>DENTAL COVERAGE</b> Underwritten by United Healthcare Insurance Company	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, CHECK COVERAGE:	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + ONE (1)	<input type="checkbox"/> RETIREE + FAMILY
<b>PLAN 1: VISION EXAM &amp; MATERIALS PLAN</b> Underwritten by United Healthcare Insurance Company	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, CHECK COVERAGE:	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + ONE (1)	<input type="checkbox"/> RETIREE + FAMILY
<b>PLAN 2: VISION MATERIALS ONLY PLAN</b> Underwritten by United Healthcare Insurance Company	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, CHECK COVERAGE:	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + ONE (1)	<input type="checkbox"/> RETIREE + FAMILY

Dependent Coverage – spouse and unmarried dependent children only. (Include Date of Birth & SSN)  
 For court-ordered dependents, documentation must be attached.

First Name	M.I.	Last Name (if different)	M/F	Date of Birth (Month/Day/Year)	Relationship	If child is over age 26, please indicate status	Enroll in:	Change or Cancel	Other Dental Coverage
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child	<input type="checkbox"/> Handicapped	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Change <input type="checkbox"/> Cancel	Other Dental Insurance: CARRIER NAME
SOCIAL SECURITY NUMBER:			<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child	<input type="checkbox"/> Handicapped	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Change <input type="checkbox"/> Cancel	Other Dental Insurance: CARRIER NAME
SOCIAL SECURITY NUMBER:			<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child	<input type="checkbox"/> Handicapped	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Change <input type="checkbox"/> Cancel	Other Dental Insurance: CARRIER NAME

I confirm that the information I have provided on this form is complete and accurate. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be prosecuted as allowed by appropriate state law.

**THIS SECTION MUST BE SIGNED AND DATED TO RECEIVE BENEFIT.**

**PENSION DEDUCTION AUTHORIZATION** - I hereby authorize the North Carolina Retirement Systems to deduct my identity theft, dental and/or vision premiums from my retirement benefit. To the best of my knowledge, I confirm that the information I have provided on this form is complete and accurate. Firefighters and Rescue Squad Workers, National Guard or Register of Deeds Pension Funds' benefit recipients do not qualify for pension deduction. Please select the Direct Bill option.

**DIRECT BILL OPTION** - Please place the benefits that I have applied for on direct bill. Firefighters and Rescue Squad Workers, National Guard or Register of Deeds Pension Funds' benefit recipients do not qualify for pension deduction. Please select the Direct Bill option.

\_\_\_\_\_  
 SIGNATURE  
 NCRS-01 (REV 5-2018)

\_\_\_\_\_  
 DATE

The UnitedHealthcare Dental plan is administered by Dental Benefit Providers, Inc.  
 The UnitedHealthcare Vision plan is administered by Spectera, Inc.

**Direct Bill Clients:** Do not send checks to Pierce Insurance Agency. You must wait for your bill to arrive from UnitedHealthcare.

See reverse side to enroll in LifeLock identity theft protection



### Identity Theft Protection Enrollment Form

The purpose of this enrollment form is for obtaining accurate data for enrolling a new member in LifeLock identity theft protection. Once you provide this form to Pierce Insurance via mail, email or fax, they will then securely transmit your enrollment data to LifeLock to begin your membership.

Social Security Number \_\_\_\_\_ Date of Retirement \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR  
 Enroll  Cancel  Change  
 Address Change  Name Change

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Change \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR  
 Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Gender  M  F  
 Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

**IDENTITY THEFT PROTECTION**  YES  NO \_\_\_\_\_ *If YES, check coverage*  RETIREE  RETIREE + ONE (1)  RETIREE + FAMILY

**ENROLLING DEPENDENTS** – spouse and unmarried dependent children only. (Include Date of Birth & SSN) For court-ordered dependents, documentation must be attached.

Enroll in  Identity Theft —OR—  Cancel  Change

*I understand that credit features in LifeLock plans require an additional validation process and until that process is complete, those dependents indicated below will be enrolled in a membership without credit features.*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR  
 Social Security Number \_\_\_\_\_ Relationship  Husband  Wife  Child Gender  M  F  
 If child is over 26, please indicate status  Handicapped Email \_\_\_\_\_

Enroll in  Identity Theft —OR—  Cancel  Change

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR  
 Social Security Number \_\_\_\_\_ Relationship  Husband  Wife  Child Gender  M  F  
 If child is over 26, please indicate status  Handicapped Email \_\_\_\_\_

Enroll in  Identity Theft —OR—  Cancel  Change

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR  
 Social Security Number \_\_\_\_\_ Relationship  Husband  Wife  Child Gender  M  F  
 If child is over 26, please indicate status  Handicapped Email \_\_\_\_\_

**ALL LIFELOCK ENROLLEES WHO SIGN BELOW ACKNOWLEDGE AND AGREE AS FOLLOWS**

I agree to the License & Service Agreement and acknowledge the Global Privacy Statement, both located at <https://www.nortonlifelock.com/us/en/legal/>.  
 I authorize NortonLifeLock Inc., its successors and assigns, in accordance with these written instructions under the Fair Credit Reporting Act to obtain my credit data from any consumer reporting agency as needed to confirm my identity, disclose my credit data to me, and deliver the services and features as available in the plan I have selected. I understand if NortonLifeLock is unable to validate or verify my identity, I will be enrolled into a plan without credit features.

▶ Retiree Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

Retiree Printed Name \_\_\_\_\_

▶ Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

Spouse Printed Name \_\_\_\_\_

▶ Adult Dependent Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

Adult Dependent Printed Name \_\_\_\_\_

I am the parent or legal guardian of the minor(s) named above and I authorize NortonLifeLock Inc., its successors and assigns, in accordance with these written instructions under the Fair Credit Reporting Act to obtain credit data from any consumer reporting agency as needed to disclose my this minor's credit data to me, and deliver the services and features as available in the plan I have selected.

▶ Signature on behalf of Minor(s) \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

Printed Name of Signer \_\_\_\_\_

**PENSION DEDUCTION AUTHORIZATION**

I hereby authorize the North Carolina Retirement Systems to deduct my identity theft, dental and/or vision premiums from my retirement benefit. To the best of my knowledge, I confirm that the information I have provided on this form is complete and accurate. Firefighters and Rescue Squad Workers, National Guard or Register of Deeds Pension Funds' benefit recipients do not qualify for pension deduction. Please select the Direct Bill option.

**DIRECT BILL OPTION**

Please place the benefits that I have applied for on direct bill. Firefighters and Rescue Squad Workers, National Guard or Register of Deeds Pension Funds' benefit recipients do not qualify for pension deduction. Please select the Direct Bill option.

Bank Name: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Checking Account  Savings Account

I authorize Selman & Company to make electronic debits or other forms of preauthorized withdrawals from my checking or savings accounts at the financial institution as indicated above, and, if necessary, initiate adjustments for any transactions credited or debited in error. I understand that if a debit or withdrawal is not honored by the financial institution, LifeLock will consider the payment unpaid. Any debit or withdrawal returned due to insufficient funds may be re-deposited by Selman & Company at its sole discretion. This authorization will remain in effect until written notice of revocation is received by Selman & Company at least five (5) business days prior to the scheduled payment date. I hereby acknowledge and agree that such preauthorized withdrawal will occur on the 15th of the month or the last business day preceding the 15th of the month if that date falls on a weekend.

I further agree that if any such debit or withdrawal is not honored, whether with or without cause, Selman & Company shall be under no liability whatsoever even though such dishonor results in the lapse of LifeLock services.

Signature of Depositor \_\_\_\_\_

GPPM1144

