UnitedHealthcare®
Dental and Vision Benefits

PIERCE INSURANCE Since 1955
Pierce Insurance Agency, Inc.
Phone: 855-627-3847

Complete form and mail, fax or email to:

ATTN: NCRS
P.O. Box 727
Farmville, NC 27828
Email: info@pierceins.com
Fax: 252-753-5941

AUTHORIZED USE ONLY

Policy Group Numbers: **708788**

☐ PVRC 0001-0001 ☐ PVRC 0002-0002
☐ PVRC 0003-0003 ☐ PVRC 0004-0004
☐ PVRC 0005-0005 ☐ PVRC 0006-0006

Dental Plan Code: **P3271**

Effective Date:

DENTAL AND VISION ENROLLMENT FORM

SOCIAL SECURITY NUMBER:	DATE OF RETIREMENT / / (Month/Day/Year)		☐ ENROLL ☐ CANCEL ☐ CHANGE ☐ ADDRESS CHANGE ☐ NAME CHANGE
LAST NAME:	FIRST NAME:	M.I.:	DATE OF BIRTH: / / (Month/Day/Year)
ADDRESS:	CITY:		
STATE: ZIP:	☐ MALE ☐ FEMALE		TELEPHONE NUMBER: ( )
EMAIL ADDRESS:			

DENTAL COVERAGE Underwritten by United Healthcare Insurance Company	☐YES ☐NO	IF YES, CHECK COVERAGE:	☐ **RETIREE**	☐ **RETIREE + ONE (1)**	☐ **RETIREE + FAMILY**
PLAN 1: VISION EXAM & MATERIALS PLAN Underwritten by United Healthcare Insurance Company	☐YES ☐NO	IF YES, CHECK COVERAGE:	☐ **RETIREE**	☐ **RETIREE + ONE (1)**	☐ **RETIREE + FAMILY**
PLAN 2: VISION MATERIALS ONLY PLAN Underwritten by United Healthcare Insurance Company	☐YES ☐NO	IF YES, CHECK COVERAGE:	☐ **RETIREE**	☐ **RETIREE + ONE (1)**	☐ **RETIREE + FAMILY**

Dependent Coverage – spouse and unmarried dependent children only. (Include Date of Birth)
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
			☐ M ☐ F	/ /	☐ Wife ☐ Husband ☐ Child	☐ Handicapped	☐ Dental ☐ Vision	☐ Change ☐ Cancel	Other Dental Insurance: CARRIER NAME
			☐ M ☐ F	/ /	☐ Wife ☐ Husband ☐ Child	☐ Handicapped	☐ Dental ☐ Vision	☐ Change ☐ Cancel	Other Dental Insurance: CARRIER NAME
			☐ M ☐ F	/ /	☐ Wife ☐ Husband ☐ Child	☐ Handicapped	☐ Dental ☐ Vision	☐ Change ☐ 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 _____ DATE _____

NCRS-01 (REV 5-2018)

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 UnitedHeathcare.

See reverse side to enroll in LifeLock identity theft protection

LifeLock by Norton

PIERCE INSURANCE SINCE 1955

Pierce Insurance Agency, Inc. Phone 855-627-3847 Fax 252-753-5941 Email info@pierceins.com Mail ATTENTION NCRS P.O. Box 727 Farmville, NC 27828

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 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

GPPM11144

SEE REVERSE SIDE TO ENROLL IN DENTAL AND VISION BENEFITS.