norton™ LifeLock Benefit Solutions

North Carolina Total Retirement Plans

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 _____

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 + 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

By submitting your enrollment in the NortonLifeLock Benefit Plan, you represent that you have the authority to enroll those dependents indicated in the NortonLifeLock Benefit Plan and you have read and agreed to the Terms and Conditions and Privacy Policy, which can be found at https://www.nortonlifelock.com/content/dam/nortonlifelock/pdfs/eulas/licensing-agreement/customer-agreement-en.pdf and https://www.nortonlifelock.com/privacy, on behalf of yourself and on behalf of any member of your family you are enrolling.

▶ 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 pensiondeduction. Please select the Direct Bill option.

Bank Name: _____

Routing Number: _____

Account Number: _____

○ Checking Account ○ Savings Account ○ Business Account

I authorize PIEDMONT Payment Services, LLC (PIEDMONT) to perform electronic funds transfer (EFT) debits on a monthly frequency from the account indicated above, and I authorize my bank to debit the account as described above. I understand that the funds will be used to pay premiums to NortonLifeLock. I also understand that NortonLifeLock will consider payment unpaid and may terminate services if any EFT attempt is returned/declined resulting in insufficient funds to pay my premiums in full. If any EFT debit is returned/declined by my financial institution as unpaid (non-sufficient funds or uncollected funds), I authorize PIEDMONT to suspend future attempts, and I understand that I will be responsible for future premium payments. I acknowledge and authorize PIEDMONT to increase the amount drafted from my bank account to $14.00 per month, if my NortonLifeLock benefit plan changes from Retiree Only at $8.00 per month to Retiree + Family at $14.00 per month.

This authorization is to remain in full force and effect until PIEDMONT has received written notification of its termination, either from the Customer named on this document or from NortonLifeLock. Notification shall be in such time and in such manner as to afford PIEDMONT a reasonable opportunity to act on it or the until the term of the authorization expires. Any termination notice should be sent to PIEDMONT by mail to: PO Box 940, Fortson, Georgia 31808 or by e-mail with reply requested to: support@piedmontpays.com. By signing this document, I acknowledge that I have read and agree with the Processing Terms and Conditions, found at http://www.piedmontterms.com

_____ _____
Signature of Depositor

GPPM11144

No one can prevent all identity theft.

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.