



# SOUTHERN CALIFORNIA PIPE TRADES PENSIONERS & SURVIVING SPOUSES HEALTH FUND

## Dental Benefit Enrollment Form

**OPEN ENROLLMENT DEADLINE: November 30, 2016**

**NOTICE:** If this form is not submitted by the deadline, your dental coverage will remain unchanged until the next open enrollment period.

You are allowed to terminate coverage at any time. However, once terminated, you may not re-enroll until the next open enrollment period.

Complete and return this form to the address above.

### SECTION 1—PARTICIPANT INFORMATION

\_\_\_\_\_  
 Pensioner Name Pensioner Social Security Number (only last 4 required)  
or T-Number

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City, State, ZIP Code

\_\_\_\_\_  
 Date of Birth (required) Phone Number Email Address

(You must use a U.S. address in order to qualify for Cigna Dental benefits.)

### SECTION 2—DENTAL BENEFIT ELECTION (check one)

I elect the following dental benefit option:

- |  | <u>Monthly Cost</u>  |
|--|--|
| <b>A</b> <input type="checkbox"/> <b>CIGNA DENTAL HMO PLAN P1-00</b> | Pensioner (or Surviving Spouse) only: \$32.48<br>Pensioner & Spouse: \$86.01 |
| <b>B</b> <input type="checkbox"/> <b>CIGNA DENTAL HMO PLAN L1-09</b> | Pensioner (or Surviving Spouse) only: \$13.72<br>Pensioner & Spouse: \$33.93 |
| <b>C</b> <input type="checkbox"/> <b>NO DENTAL COVERAGE</b>          | <b>Skip to Section 5</b>   |

### SECTION 3—DENTAL COVERAGE ELECTION (check one)

I elect to cover:

- A**  MYSELF ONLY
- B**  MYSELF AND MY SPOUSE

**Continued on reverse...**

**SECTION 4—ACH ELECTRONIC PAYMENT AUTHORIZATION**

COMPLETE THIS SECTION **ONLY** IF YOU ARE **NOT** RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND.

By signing in Section 5 below, I authorize the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund to electronically withdraw from or deposit into my checking or savings account indicated below amounts necessary to provide dental benefits as determined by the Board of Trustees of the Fund.	
<b>Depository Name</b> (Bank, Savings & Loan or Credit Union)	
<b>Transit/ABA/Routing Number</b>	<b>Account Number</b>
<b>Account Type</b> <input type="checkbox"/> Checking <input type="checkbox"/> Savings	<b>Email Address</b> (Fund's bank may notify you of withdrawals or deposits)
<b>Your Social Security Number</b> (only last four required)	<b>Your Home Telephone Number</b>
This authorization will remain in full force and effect until the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund has received, at least two weeks before the scheduled payment date, written notification from me that I want to revoke this authorization.	
<b><i>Account holder must verify bank account data. Please attach a voided check.</i></b>	

**SECTION 5—PARTICIPANT AGREEMENT AND SIGNATURE**

I have read and understand the material describing the dental benefits provided to me and if I had any questions, I have asked them of the Southern California Pipe Trades Administrative Corporation or Cigna and have received acceptable answers.

I understand that if I make no election my dental coverage will remain unchanged.

I understand that I will not be permitted to enroll in or change my dental plan until the first of the year following the next open enrollment period, which is scheduled for October 1, 2017—November 30, 2017.

NOTE: If you elect the Cigna Dental HMO option, Cigna will initially assign you to a dentist based on your address in our records. You will be permitted to change your dentist by contacting Cigna after you are enrolled.

**I HEREBY AUTHORIZE THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND TO DEDUCT FROM MY MONTHLY BENEFIT PAYMENTS SUCH SUMS AS ARE PERIODICALLY ESTABLISHED BY THE TRUSTEES OF THE SOUTHERN CALIFORNIA PIPE TRADES PENSIONERS & SURVIVING SPOUSES HEALTH FUND TO PROVIDE DENTAL COVERAGE UNDER THAT FUND.** I understand that this amount will likely increase over time. I make this authorization voluntarily and understand that it may be revoked at any time. By this authorization, I am not assigning my monthly benefit payment or any portion thereof, to the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund. I understand that the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund has no right, enforceable against the Southern California Pipe Trades Retirement Fund, to any part of the monthly pension benefit.

I understand that if this authorization is revoked, I must provide an ACH Authorization Form so that my monthly dental premiums can be deducted from my bank account. I also understand that failure to do so will result in the loss of dental coverage under the Pensioner and Surviving Spouses Health Fund. I understand that no other forms of payment will be accepted.

**IF I AM NOT RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND, I HAVE COMPLETED THE ACH AUTHORIZATION IN SECTION 4 ABOVE.**

  X    
Participant Signature

\_\_\_\_\_  
Date