

Please see other side on how to apply...

PLEASE PRINT CLEARLY.

PASR MEMBER - APPLICANT								
Social Security Number _ _ - _ -	Last Name	First			M.I.			
Street Address					Telephone ()			
City	State	Zip	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (Mo/Day/Yr) / /				
Email Address								
COVERAGE DESIRED & ANNUAL PREMIUMS <small>(Please ✓ one) Premiums include a Third Party Administration fee.</small>								
<input type="checkbox"/> Individual (Applicant Only) \$412		<input type="checkbox"/> Two-Party (Applicant Plus One) \$795 complete information below			<input type="checkbox"/> Family (Applicant Plus Two or More) \$1,229 complete information below			
FAMILY MEMBERS - DEPENDENTS								
	Social Security No.	Last Name	First		M.I.	Sex M/F	Birth Date Mo/Day/Yr	Disabled Yes/No
Spouse								
<small>For dependent children age 19 or older call 1-800-382-1352 for a Dependent Certification form.</small>								
Child								
Child								
Child								
PAYMENT METHOD								
<input type="checkbox"/> Enclosed Check/Money Order (please make check payable to "PISI")								
Credit Card: Card No. _____ Exp. Date _____ CVV Code* _____ Please check one... <small>*Three digit code on back of card</small> <input type="checkbox"/> MasterCard _____ <input type="checkbox"/> Visa _____ Cardholder's Name, as it appears on Credit Card <input type="checkbox"/> Discover _____ _____ Cardholder's Address (if different from applicant) <div style="display: flex; justify-content: space-between;"> X Signature (for Credit Card authorization only) X Date </div>								

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, we may deposit that check for collection a second time.

X _____ **X** _____
Applicant's Signature **Date**

HOW TO APPLY:

1. To apply for Dental coverage, please complete this Application. To apply for both Dental **and** Vision Plans, fully complete, sign and date **both** Dental and Vision Applications.
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 19, unmarried students to age 25, disabled dependents to any age. ***If enrolling a dependent age 19 or older please call 1-800-382-1352 for a Dependent Certification form which must be completed and returned with your application.***

ANNUAL DENTAL PREMIUMS	
Individual	\$412
Two-Party	\$795
Family	\$1,229

3. Full annual premiums must be submitted for the type of coverage you choose. Payment options are: check; MasterCard, Visa or Discover credit cards; money order; or Monthly Withdrawal from your checking account*. Checks are to be made payable to "PISI". You may send one check/money order to cover the combined premiums if you choose both Dental and Vision.

**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.*

4. Mail the fully completed Application(s) and your payment using the enclosed postage-paid envelope to: Professional Insurance Services, Inc., 1023 Mumma Road, Lemoyne, PA 17043. **If your Application(s) and payment are received at PISI by the 20th of the current month, the coverage will become effective the 1st of the following month.** You will receive a letter from our Administrator that will acknowledge receipt of your Application(s) and payment and give you the effective date and anniversary date of your coverage.

IMPORTANT NOTICE:

The Pennsylvania Association of School Retirees (PASR) endorses United Concordia Dental and Davis Vision Plans for retirees who are 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.

Questions can be directed to the PASR state office in Mechanicsburg: (717) 697-7077 or PASR, 878 Century Drive, Mechanicsburg PA 17055.