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Enrollment and Change Form for NCRGEA
The Standard Insurance Company Group Dental Coverage

North Carolina Retired Governmental Employees' Association

Group Name: **NORTH CAROLINA RETIRED GOVERNMENTAL EMPLOYEES' ASSOCIATION** Group Number: **160-758158**

4 ways to enroll

1. Online Self Enrollment Portal at markiiieb.com/enroll
2. Call Center Enrollment with Mark III Employee Benefits toll-free 833-444-5220
3. Online Form Submission through the NCRGEA Website www.ncrgea.com
4. Mail application in enclosed envelope to NCRGEA, 528 Wade Ave, Raleigh, NC 27605, or fax application to 919-834-4622

Please complete all information to enroll, make changes, or terminate.

Member ID # 123

Member Name: _____
(Last) (First) (Middle Initial)

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security Number: _____

Date of Birth: **Month** _____ **Day** _____ **Year** _____

Land Line Phone (Include Area Code): _____

Cell Phone (Include Area Code): _____

Email Address: _____

To ENROLL or CHANGE plan, select:

Member Only Coverage
☐ High Plan $47.76/mo. ☐ Low Plan $36.12/mo.

Member and Child(ren)*
☐ High Plan $74.40/mo. ☐ Low Plan $70.56/mo.

Member and Associate **
☐ High Plan $95.52/mo. ☐ Low Plan $72.24/mo.

Member and Spouse
☐ High Plan $107.48/mo. ☐ Low Plan $86.56/mo.

Member and Spouse and Child(ren)*
☐ High Plan $133.68/mo. ☐ Low Plan $119.96/mo.

* (Children may be covered until their 26th birthday, unless disabled)
** (Associate is a dues paying spouse of an active NCRGEA Member)

To ADD or DROP dependents, change plan level, or terminate coverage, fill out this section and circle ADD or DROP:

Spouse Name: _____ M / F Date of Birth _____ ADD/DROP

Child Name: _____ M / F Date of Birth _____ ADD/DROP

Child Name: _____ M / F Date of Birth _____ ADD/DROP

Child Name: _____ M / F Date of Birth _____ ADD/DROP

Changes in Dependent Coverage will be effective: _____

☐ **Terminate my dental coverage effective:** _____

Signature: _____ **Date:** _____
Your signature is required for changes.

PAYROLL DEDUCTION AUTHORIZATION:

I received and read a copy of the NCRGEA's current description of the group dental plan insured and administered by The Standard Insurance Company. If I qualify for payroll deduction, I agree to remain in the NCRGEA Dental Plan until December 31, 2022. By signing below, I declare that all the information given in this enrollment form is true and complete to the best of my knowledge and belief. **I hereby authorize the North Carolina Retirement System to deduct from my retirement check my membership dues and/or my monthly dental plan premium indicated above. When NCRGEA membership dues have been paid for the current year, my dues deduction will begin the month before the scheduled renewal date.** This authorization applies to such coverage until I rescind it in writing.

My annual dues are: ☐ $15.00 ($1.25 monthly) ☐ $25.00 ($2.09 monthly) ☐ $40.00 ($3.34 monthly)

Signature: _____ **Date:** _____