2111 Palomar Airport Road
Suite 330
San Diego, CA 92011
(800) 733-4487
(858) 622-5000

Application Instructions:

- Complete all sections of the application with signature and date.
- Complete Authorization for Direct Automatic Bill Payment form.
- Enclose a voided check. (Deposit slips will not be accepted)
- Mail package to:

Pacific Financial Designs, Inc.
2111 Palomar Airport Road
Suite 330
San Diego, CA 92011
Attn: New Benefits

- All enrollments received by the 15th of the month will be effective the 1st of the following month. Those received after the 15th will not be processed until the following month with an effective date of the following 1st of the month.
    - Example: Application received on August 14th will be effective September 1st, but an application received on August 17th will be effective October 1st.

RETIRED PEACE OFFICERS ASSOCIATION of CALIFORNIA **DENTAL BENEFITS APPLICATION**

GENERAL INFORMATION

Name (Last, First, MI)	ID #	Social Security Number / /	Gender ☐ M ☐ F	Date of Birth (MM/DD/YY)	Date of Retirement	Policy Number 715049
Member's email address		**Event** ☐Open Enrollment ☐Other:		Effective Date of Coverage	Home Phone # ( )	
Residence Mailing Address		Apt./Unit #	City		Zip	State

DENTAL ENROLLMENT

Choose from the following dental plans. (☑ the box that applies)	**Pacific Union Dental (CA only) Imperial**	**HMO Dental UHC/PacifiCare (CA only)**	**PPO Dental UnitedHealthcare**
	Monthly	**Monthly**	**Monthly**
Member Only	☐ $30.18	☐ $16.51	☐ $ 44.94
Member + One	☐ $51.61	☐ $31.25	☐ $ 88.17
Member + Two or More	☐ $76.95	☐ $47.68	☐ $147.48
Plan Code	☐ 0004	☐ 0005	☐ 0003

MEMBER/DEPENDENT INFORMATION

Name (Last, First, MI)	Relationship	Gender	Date of Birth (MM/DD/YY)	Full-time Student	Dental Provider Name & City (HMO Only)	Patient Existing	Group # (HMO) Dental Provider
	Member					☐Yes ☐No	
	☐Spouse ☐Dom. Part.	☐M ☐F				☐Yes ☐No	
	Child	☐M ☐F		☐Yes ☐No		☐Yes ☐No	
	Child	☐M ☐F		☐Yes ☐No		☐Yes ☐No	
	Child	☐M ☐F		☐Yes ☐No		☐Yes ☐No	

Do you or your dependents have any other dental insurance? If "Yes", complete the following information:

Benefit	Insurance Company	Policy #	Who is covered under this other policy?
☐ Dental			
☐ Dental			
☐ Dental			

Signature

I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY ASSOCIATION TO MAKE THE NECESSARY DEDUCTION(S) FROM MY MEMBERSHIP TO PAY MY PORTION OF THE PREMIUM.

ARBITRATION DISCLOSURE: I agree that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and United HealthCare, Pacific Union Dental and PacifiCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. If I choose not to enroll at the time I first become eligible, I and my eligible dependents will not be allowed to enroll until the next open enrollment period.

_____ (Date)

_____ (Signature)

AUTHORIZATION FOR DIRECT AUTOMATIC BILL PAYMENT

Company Name: Benefit Service Center, Inc. (the "Company)

I (we) authorize the Company to initiate variable entries to my (our) account described below:

Checking Acct. No. _____ Savings Acct. No. _____

Financial Institution Name: _____

Financial Institution Address: _____

_____

A voided check from the account mentioned above is required

Please do not attach deposit slips

This authority is to remain in full force and effect until the Company has received written notification from me (or either one of us) of its termination in such time and manner to afford the Company a reasonable opportunity to act on it. By signing this authorization, you agree to a flat fee of $2.00 per month for administration costs.

Signature _____

Full Name _____

Address _____

_____

Date _____

Telephone _____

Policy No. _____

(Optional - For Joint Account)

Signature _____

Full Name _____

Date _____

Telephone _____

Office Use Only

Representative _____ First Batch _____

Agent _____ Notes _____

Policy _____

BSC/ACH/01.20.09