




UnitedHealthcare
Dental and Vision Benefits
LifeLock Identity Theft Plan
Allstate Benefits
Critical Illness & Accident

Underwritten by American Heritage Life Insurance Company

AUTHORIZED USE ONLY	
Policy Group Numbers:	708788
Plan Variation/Reporting Code:	
<input type="checkbox"/> PVRC 0001-0001	<input type="checkbox"/> PVRC 0002-0002
<input type="checkbox"/> PVRC 0003-0003	<input type="checkbox"/> PVRC 0004-0004
<input type="checkbox"/> PVRC 0005-0005	<input type="checkbox"/> PVRC 0006-0006
Dental Plan Code:	P3271
Group Critical Illness & Accident Account Number:	15934
Effective Date:	

Complete form and mail, fax or email to:

Pierce Insurance Agency, Inc.

E-mail: info@pierceins.com

ATTN: NCRS

Phone: 855-627-3847

P.O. Box 727

Fax: 252-753-5941

Farmville, NC 27828

IDENTITY THEFT, CRITICAL ILLNESS, ACCIDENT, DENTAL, AND VISION ENROLLMENT FORM

SOCIAL SECURITY NUMBER:		DATE OF RETIREMENT / / (Month/Day/Year)		<input type="checkbox"/> ENROLL	<input type="checkbox"/> CANCEL	<input type="checkbox"/> CHANGE
LAST NAME:		FIRST NAME:	MI.:	DATE OF CHANGE: / / (Month/Day/Year)		
ADDRESS:		CITY:		DATE OF BIRTH: / / (Month/Day/Year)		
STATE:	ZIP:	TELEPHONE NUMBER: ()		EMAIL ADDRESS:		
<input type="checkbox"/> MALE <input type="checkbox"/> SINGLE <input type="checkbox"/> FEMALE <input type="checkbox"/> MARRIED		BENEFICIARY:		RELATIONSHIP TO INSURED: <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> SIBLING <input type="checkbox"/> OTHER		Has the primary insured (or spouse if covered) used tobacco in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO

LIFELock IDENTITY THEFT PLAN	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, CHECK COVERAGE:	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + ONE (1)	<input type="checkbox"/> RETIREE + FAMILY
CRITICAL ILLNESS COVERAGE Underwritten by American Heritage Life Insurance Company	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, CHECK COVERAGE:	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + SPOUSE	<input type="checkbox"/> RETIREE + CHILD(REN) <input type="checkbox"/> FAMILY
ACCIDENT COVERAGE Underwritten by American Heritage Life Insurance Company	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, ELECT PLAN & CHECK COVERAGE: <input type="checkbox"/> LOW PLAN <input type="checkbox"/> HIGH PLAN	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + SPOUSE	<input type="checkbox"/> RETIREE + CHILD(REN) <input type="checkbox"/> FAMILY
DENTAL COVERAGE Underwritten by United Healthcare Insurance Company	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, CHECK COVERAGE:	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + ONE (1)	<input type="checkbox"/> RETIREE + FAMILY
PLAN 1: VISION EXAM & MATERIALS PLAN Underwritten by United Healthcare	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, CHECK COVERAGE:	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + ONE (1)	<input type="checkbox"/> RETIREE + FAMILY
PLAN 2: VISION MATERIALS ONLY PLAN Underwritten by United Healthcare Insurance Company	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, CHECK COVERAGE:	<input type="checkbox"/> RETIREE	<input type="checkbox"/> RETIREE + ONE (1)	<input type="checkbox"/> RETIREE + FAMILY

Dependent Coverage – spouse and unmarried dependent children only. (Include Date of Birth & SSN)

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
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child	<input type="checkbox"/> Handicapped	<input type="checkbox"/> ID Theft <input type="checkbox"/> Critical Illness <input type="checkbox"/> Accident <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Change <input type="checkbox"/> Cancel	Other Dental Insurance: CARRIER NAME
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child	<input type="checkbox"/> Handicapped	<input type="checkbox"/> ID Theft <input type="checkbox"/> Critical Illness <input type="checkbox"/> Accident <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Change <input type="checkbox"/> Cancel	Other Dental Insurance: CARRIER NAME
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child	<input type="checkbox"/> Handicapped	<input type="checkbox"/> ID Theft <input type="checkbox"/> Critical Illness <input type="checkbox"/> Accident <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Change <input type="checkbox"/> 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, critical illness, accident, 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
NCRS-01 (2016)

DATE