AUTHORIZED USE ONLY	
Policy Group Numbers:	708788
☐ PVRC 0001-0001 ☐ PVRC 0003-0003 ☐ PVRC 0005-0005	☐ PVRC 0002-0002 ☐ PVRC 0004-0004 ☐ PVRC 0006-0006
Dental Plan Code:	P3271
Effective Date:	

UnitedHealthcare®

Dental and Vision Benefits

PIERCE INSURANCE SINCE 1955

Pierce Insurance Agency, Inc.
Phone: 855-627-3847
Fax: 252-753-5941

Complete form and mail, fax or email to:

ATTN: NCRS
P.O. Box 727
Farmville, NC 27828
E-mail: info@pierceins.com

DENTAL AND VISION ENROLLMENT FORM

SOCIAL SECURITY NUMBER:	DATE OF RETIREMENT / / (Month/Day/Year)		☐ ENROLL ☐ CANCEL ☐ CHANGE ☐ ADDRESS CHANGE ☐ NAME CHANGE
LAST NAME:	FIRST NAME:	M.I.:	DATE OF CHANGE: / / (Month/Day/Year)
ADDRESS:	CITY:		DATE OF BIRTH: / / (Month/Day/Year)
STATE: ZIP:	☐ MALE ☐ FEMALE		EMAIL ADDRESS:
TELEPHONE NUMBER: ( )			

DENTAL COVERAGE Underwritten by United Healthcare Insurance Company	☐YES ☐NO	IF YES, CHECK COVERAGE:	☐ **RETIREE**	☐ **RETIREE + ONE (1)**	☐ **RETIREE + FAMILY**
PLAN 1: VISION EXAM & MATERIALS PLAN Underwritten by United Healthcare Insurance Company	☐YES ☐NO	IF YES, CHECK COVERAGE:	☐ **RETIREE**	☐ **RETIREE + ONE (1)**	☐ **RETIREE + FAMILY**
PLAN 2: VISION MATERIALS ONLY PLAN Underwritten by United Healthcare Insurance Company	☐YES ☐NO	IF YES, CHECK COVERAGE:	☐ **RETIREE**	☐ **RETIREE + ONE (1)**	☐ **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**
SOCIAL SECURITY NUMBER:			☐ M ☐ F	/ /	☐ Wife ☐ Husband ☐ Child	☐ Handicapped	☐ Dental ☐ Vision	☐ Change ☐ Cancel	Other Dental Insurance: CARRIER NAME
SOCIAL SECURITY NUMBER:			☐ M ☐ F	/ /	☐ Wife ☐ Husband ☐ Child	☐ Handicapped	☐ Dental ☐ Vision	☐ Change ☐ Cancel	Other Dental Insurance: CARRIER NAME
SOCIAL SECURITY NUMBER:			☐ M ☐ F	/ /	☐ Wife ☐ Husband ☐ Child	☐ Handicapped	☐ Dental ☐ Vision	☐ Change ☐ 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, 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 DATE

NCRS-01 (REV 5-2018)

The UnitedHealthcare Dental plan is administered by Dental Benefit Providers, Inc.
The UnitedHealthcare Vision plan is administered by Spectera, Inc.

See reverse side to enroll in LifeLock identity theft protection

LifeLock®

PIERCE INSURANCE SINCE 1955

Pierce Insurance Agency, Inc.
Phone 855-627-3847
Fax 252-753-5941

ATTENTION NCRS
P.O. Box 727
Farmville, NC 27828
Email info@pierceins.com

Identity Theft Enrollment Form

Social Security Number ____________ Date of Retirement ____ / ____ / ____ (MONTH DAY YEAR)

○ Enroll ○ Cancel ○ Change ○ Address Change ○ Name Change

Last Name ____________ First Name ____________ MI ____

Date of Change ____ / ____ / ____ (MONTH DAY YEAR)

Address ____________________

Date of Birth ____ / ____ / ____ (MONTH DAY YEAR)

City ____________ State ______ Zip ____________

Gender ○ M ○ F

Phone (______) ______ – ________ Email ____________

LIFELOCK IDENTITY THEFT PLAN ○ YES ○ NO *If YES, check coverage* ○ **RETIREE** ○ **RETIREE + ONE (1)** ○ **RETIREE + FAMILY**

ENROLLING DEPENDENTS – spouse and unmarried dependent children only. (Include Date of Birth & SSN) For court-ordered dependents, documentation must be attached.

Enroll in ○ Identity Theft *—OR—* ○ Cancel ○ Change

Last Name ____________ First Name ____________ MI ____ Date of Birth ____ / ____ / ____ (MONTH DAY YEAR)

Social Security Number ____________ Relationship ○ Husband ○ Wife ○ Child Gender ○ M ○ F

If child is over 26, please indicate status ○ Handicapped Email ____________

Enroll in ○ Identity Theft *—OR—* ○ Cancel ○ Change

Last Name ____________ First Name ____________ MI ____ Date of Birth ____ / ____ / ____ (MONTH DAY YEAR)

Social Security Number ____________ Relationship ○ Husband ○ Wife ○ Child Gender ○ M ○ F

If child is over 26, please indicate status ○ Handicapped Email ____________

Enroll in ○ Identity Theft *—OR—* ○ Cancel ○ Change

Last Name ____________ First Name ____________ MI ____ Date of Birth ____ / ____ / ____ (MONTH DAY YEAR)

Social Security Number ____________ Relationship ○ Husband ○ Wife ○ Child Gender ○ M ○ F

If child is over 26, please indicate status ○ Handicapped Email ____________

LIFELOCK NEEDS THE SIGNATURES OF ALL ENROLLEES. ALL LIFELOCK ENROLLEES WHO SIGN BELOW ACKNOWLEDGE AND AGREE AS FOLLOWS.

I accept the LifeLock Terms and Conditions and Privacy found at https //www.lifelock.com/legal and I am providing my "written instructions" under the Fair Credit Reporting Act authorizing LifeLock, its successors and assigns, to obtain my credit data from any consumer reporting agency on a recurring basis in order to confirm my identity, disclose my credit data to me, and monitor my credit data in order to create and deliver certain services and features to me as available in the plan I have selected. I understand that the LifeLock credit services may require an additional validation process and until it is complete, I will be enrolled in a LifeLock subscription without credit features.

Retiree Signature ____________________ Date ____/____/____

Retiree Printed Name ____________________

Spouse Signature ____________________ Date ____/____/____

Spouse Printed Name ____________________

Dependent Signature ____________________ Date ____/____/____

Dependent Printed Name ____________________

Dependent *(if signing on behalf of a minor)* ____________________ Date ____/____/____

SIGNATURE ____________________ Date ____/____/____

○ **PENSION DEDUCTION AUTHORIZATION**
I hereby authorize the North Carolina Retirement Systems to deduct my identity theft, 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.

Bank Name: ____________

Routing Number: ____________

Account Number: ____________

○ Checking Account ○ Savings Account

I authorize Selman & Company to make electronic debits or other forms of preauthorized withdrawals from my checking or savings accounts at the financial institution as indicated below, and, if necessary, initiate adjustments for any transactions credited or debited in error. I understand that if a debit or withdrawal is not honored by the financial institution, LifeLock will consider the payment unpaid. Any debit or withdrawal returned due to insufficient funds may be re -deposited by Selman & Company at its sole discretion. This authorization will remain in effect until written notice of revocation is received by Selman & Company at least five (5) business days prior to the scheduled payment date. I hereby acknowledge and agree that such preauthorized withdrawal will occur on the 15th of the month or the last business day preceding the 15th of the month if that date falls on a weekend.

I further agree that if any such debit or withdrawal is not honored, whether with or without cause, Selman & Company shall be under no liability whatsoever even though such dishonor results in the lapse of LifeLock services.

____
Signature of Depositor

SEE REVERSE SIDE TO ENROLL IN DENTAL AND VISION BENEFITS.

No one can prevent all identity theft.
† LifeLock does not monitor all transactions at all businesses.

NCRS-01 (REV 8-2018)