UnitedHealthcare®
Dental and Vision Benefits

PIERCE INSURANCE SINCE 1955
Pierce Insurance Agency, Inc.
Phone: 855-627-3847

Complete form and mail, fax or email to:

ATTN: NCRS
P.O. Box 727
Farmville, NC 27828
Email: info@pierceins.com
Fax: 252-753-5941

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:

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 BIRTH: / / (Month/Day/Year)
ADDRESS:	CITY:		
STATE: ZIP:	☐ MALE ☐ FEMALE		TELEPHONE NUMBER: ( )
EMAIL ADDRESS:			

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)
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
First Name	M.I.	Last Name (if different)	☐ M ☐ F	/ /	☐ Wife ☐ Husband ☐ Child	☐ Handicapped	☐ Dental ☐ Vision	☐ Change ☐ Cancel	Other Dental Insurance: CARRIER NAME
First Name	M.I.	Last Name (if different)	☐ M ☐ F	/ /	☐ Wife ☐ Husband ☐ Child	☐ Handicapped	☐ Dental ☐ Vision	☐ Change ☐ Cancel	Other Dental Insurance: CARRIER NAME
First Name	M.I.	Last Name (if different)	☐ 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.

Direct Bill Clients: Do not send checks to Pierce Insurance Agency. You must wait for your bill to arrive from UnitedHealthcare.