**Retire MM/YR:_____/_____** **ENROLLMENT FORM**

**COOK COUNTY PENSION FUND VOLUNTARY DENTAL PLAN**

***INCOMPLETE APPLICATIONS WILL BE RETURNED*/Check if you are current member but switching plan ( )**

| PLANHOLDER NAME<br>The County Employees' and Officers' Annuity and Benefit Fund of Cook County and the Forest Preserve District Employees' Annuity and Benefit Fund of Cook County | | | | GROUP NUMBER<br>475274 |
|---|---|---|---|---|
| MEMBER NAME LAST NAME | | MEMBER FIRST NAME | | MIDDLE INITIAL |
| MEMBER'S STREET ADDRESS | | SOCIAL SECURITY NUMBER<br>_____-___-_____ | | PRIMARY CARE DENTIST<br>**(For D-HMO only)**<br>☐☐☐☐☐☐ |
| CITY | ST | ZIP | TELEPHONE<br>( _____ )_____-_____ | BIRTH DATE<br>____/____/_____ |
| MARITAL STATUS:<br>☐ SINGLE ☐ MARRIED ☐ LEGALLY SEPARATED ☐ DIVORCED | | | | SEX<br>☐ FEMALE ☐ MALE |
| CHECK PLAN REQUESTED:<br>☐ **DHMO DENTAL PLAN (available in IL/NW IN only)**<br>☐ **PPO DENTAL PLAN (Nationwide)** | | | | DEPENDENT CHILD(REN):<br>☐ YES ☐ NO |

**SPOUSE/DEPENDENT ENROLLMENT FOR INSURANCE**

| LIST EACH DEPENDENT NAME (LAST, FIRST, MIDDLE INITIAL) | SEX | RELATIONSHIP | SSN | DATE OF BIRTH | PRIMARY CARE DENTIST # (DHMO Only) |
|---|---|---|---|---|---|
| | ☐ F<br>☐ M | | | | |
| | ☐ F<br>☐ M | | | | |
| | ☐ F<br>☐ M | | | | |
| | ☐ F<br>☐ M | | | | |
| | ☐ F<br>☐M | | | | |

Are any dependent children adopted? ☐ YES ☐ NO If "yes," indicate name & date of adoption

_____

Have you included stepchildren as dependents? ☐ YES ☐ NO If "yes" indicate name/s

_____

Do your stepchildren reside with you? ☐ YES ☐ NO Are they dependent upon you for support and maintenance? ☐ YES ☐ NO

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverage's that I have chosen above.
- I accept the payment conditions and wish to enroll.
- I attest that the information provided above is true and correct to the best of my knowledge.

| **Signature of Retiree**<br>X | **Date** |
|---|---|

**Email Address:**

**Both front and back of form must be filled out completely in order to process the enrollment. – Revised 8/2026**

**PAYMENT AUTHORIZATION FORM**
**THIS IS NOT STANDARD DISCLAIMER, PLEASE READ CAREFULLY**

Premiums for this program are collected one month in advance of the coverage month, typically around the 10th. All mailed payments must be received by the 15th of the month preceding the start of the next month's coverage. **Please note that we do not send monthly invoice statement reminders. Failure to pay premiums will result in automatic cancellation of your coverage**.

We offer only auto draft payment options, which include debit or credit cards with a VISA/MASTER Logo.
This method authorizes Risk Management Solutions of America (RMSOA) to automatically debit your card for the selected premium. To avoid cancellation, please promptly notify RMSOA of any changes to your account information. It's important to understand that the act of deducting premiums does not automatically grant coverage. Upon confirmation of your membership in the Fund and your good standing, Guardian will mail you a membership card within a few weeks of RMSOA receiving this information.

Regarding disputes, it is essential to express any concerns or disputes to RMSOA before taking any further action. You agree not to dispute or charge back your credit card without first informing RMSOA of your intent to do so, if you do, it will result in a penalty fee imposed by the banking institution. Please keep in mind that Risk Management Solutions will appear as the vendor/merchant on your credit/debit card statements.

| **Please Select Payment Method:** | |
|---|---|
| ☐ Check or Money Order<br><br>☐ DHMO Single - $10.60<br>☐ DHMO Family - $28.02<br>☐ PPO Single - $31.34<br>☐ PPO Family - $59.76 | Mail checks and money orders monthly to:<br>(We do not offer direct withdrawal from checking accounts)<br>**Risk Management Solutions of America**<br>**Guardian Dental Program**<br>**309 W. Washington St. Suite 500**<br>**Chicago, IL 60606** |

| | | |
|---|---|---|
| ☐ Visa/Mastercard<br><br>☐ DHMO Single - $11.02<br>☐ DHMO Family - $29.14<br>☐ PPO Single - $32.59<br>☐ PPO Family - $62.15 | Name as it appears on card: | |
| | Credit Card Number: | |
| | Expiration (MM/YY): | |
| | Card Security Code (last 3 digits on back of card): | |

*For Credit/Debit Card Payors That Provide An Email Will Receive Receipt Email Notifications From **Authorize.Net***

**Signature of premium payer** **Date**

My signature hereby authorizes Risk Management Solutions of America to draft my credit/debit card (Master/Visa Only) as listed above on or near the 10th of each month for the purpose of collecting premiums for the County Employees' and Officers' Annuity and Benefit Fund of Cook County and the Forest Preserve District Employees' Annuity and Benefit Fund of Cook County Dental Program I have accepted.

**Please send Enrollment and Payment Authorization Form to:**
Risk Management Solutions of America, Inc.
309 W. Washington Street Suite 500
Chicago, IL 60606
Phone: (877)522-2524-press (**#1** Re: Premiums/Enrollment) (**#2** HMO Coverage Questions) (**#3** PPO Coverage Questions)
Fax: (312) 960-1920