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 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 475274
MEMBER NAME LAST NAME		MEMBER FIRST NAME		MIDDLE INITIAL
MEMBER'S STREET ADDRESS		SOCIAL SECURITY NUMBER _____-___-_____		**HMO**-must place Primary Care Dentist number in below boxes. ☐☐☐☐☐☐ Provider list found at: www.Guardianlife.com
CITY	ST / ZIP	TELEPHONE (_____)_____-_____		BIRTH DATE ____/____/_____
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ LEGALLY SEPARATED ☐ DIVORCED				SEX ☐ FEMALE ☐ MALE
CHECK PLAN REQUESTED: ☐ **DHMO DENTAL PLAN (available in IL/NW IN only)** ☐ **PPO DENTAL PLAN (Nationwide)**				DEPENDENT CHILD(REN): ☐ YES ☐ NO

LIST DEPENDENTS BELOW (Spouse & children) ENROLLMENT FOR INSURANCE

LIST EACH DEPENDENT NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	RELATIONSHIP	SSN	DATE OF BIRTH	**P**RIMARY **C**ARE **D**ENTIST # (DHMO Only)
	☐ F ☐ M				
	☐ F ☐ M				
	☐ F ☐ M				
	☐ F ☐ M				
	☐ F ☐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 **X**	**Date**

Email Address:

Both pages of form must be filled out completely in order to process the enrollment.

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

The premiums for this program are collected a month in advance that they are due. The collection of premiums will occur on or about the **10th** and all mailed payments must be received no later than the **15th** of the month prior to the start of the next month coverage. **Monthly invoice statements will not be mailed to you**. **Nonpayment of premiums will result in automatic cancellation of coverage.**

If you select credit or debit card (VISA/MASTER) as your method of payment it is authorizing Risk Management Solutions of America (RMSOA) to automatically debit your card for the selected premium. To avoid cancelation please notify RMSOA immediately of any changes in your account information. The act of deducting premium does not constitute coverage. A membership card mailed by Guardian within a few weeks of RMSOA receiving confirmation that you are a member of the Fund and in good standing.

Disputes: You agree that any disputes shall be expressed to RMSOA before action is taken. You agree not to dispute or charge-back your credit card without first informing RMSOA of your intent to do so.

Please Select Payment Method:	
☐ Check or Money Order ☐ DHMO Single - $10.29 ☐ DHMO Family - $27.20 ☐ PPO Single - $30.43 ☐ PPO Family - $58.02	Remit checks and money orders to: **Risk Management Solutions of America** **Guardian Dental Program** **309 W. Washington St. Suite 200** **Chicago, IL 60606**

☐ Visa/Mastercard ☐ DHMO Single - $10.75 ☐ DHMO Family - $28.42 ☐ PPO Single - $31.80 ☐ PPO Family - $60.63	Name as it appears on card:	
	Credit Card Number:	
	Expiration (MM/YY):	
	Card Security Code (last 3 digits on back of card):	

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 200
Chicago, IL 60606
Phone: (877)522-2524-press (**#1** Re: Premiums/Enrollment) (**#2** HMO Coverage Questions) (**#3** PPO Coverage Questions)
Fax: (312) 960-1920

Both pages of form must be filled out completely in order to process the enrollment.