PARSE APPLICATION and DENTAL & VISION ENROLLMENT FORM

PISI Insurance Administrator

1.) Complete the application by following Step 1 - 5
2.) Return the application in the enclosed postage-paid envelope.
3.) **PISI must receive your fully completed application and all required payments by the 20th of a month for your effective date to be the 1st of the following month. Failure to send required payments may delay your effective date.**
Be sure to include: Payment for PARSE dues and payment for insurance (annual or 1st month)

STEP 1: TELL US ABOUT YOURSELF

Name:

Address:

Gender:
☐ Male
☐ Female

Date of Birth: ___/___/_____
MM DD YYYY

SSN (Required for insurance purposes):

Phone Number: (___) _____-_____

Email Address:

STEP 2: PARSE MEMBERSHIP ENROLLMENT FORM: *(These plans are available to PARSE members only)*

Select One:
☐ Chapter Member *(Retiree/Active Employee)*
☐ Associate Member *(Non-Retiree, Spouse/ domestic partner of Retiree*)*
☐ Member-at-Large *(No Chapter Designation)*

Chapter Number (choose from reverse): _____

Year Retired: _____

Former or Current Agency: _____

☐ **Member Only:** My $20 check for membership is enclosed
☐ **Member +Spouse:** My $40 check for membership is enclosed
(Spouse or Domestic Partner must become a PARSE Member (Associate or Chapter, as appropriate) to be eligible for benefits)

▶ _____
Signature Date

▶ _____
Spouse Signature Date

Make membership checks payable to PARSE. See Local Chapter List on reverse. New members will be assigned to the chapter in the geographic area. Chapter may be changed at any time upon member request. PARSE membership is valid from January 1 to December 31 of the current calendar year. Any new member enrolling in October, November or December of any year will be a member for the remainder of that year plus the following calendar year. This applies to new members only and does not apply to anyone previously a PARSE member.

STEP 3: SELECT YOUR COVERAGE

	Dental		Standard Vision		Enhanced Vision	
	1st MONTH RATE	ANNUAL RATE	1st MONTH RATE	ANNUAL RATE	1st MONTH RATE	ANNUAL RATE
Individual	☐ $39.23	☐ $449.00	☐ $6.24	☐ $74.00	☐ $7.50	☐ $90.00
Two Party	☐ $72.49	☐ $849.00	☐ $10.99	☐ $131.00	☐ $13.50	☐ $162.00
Family	☐ $111.24	☐ $1314.00	☐ $15.87	☐ $190.00	☐ $20.87	☐ $250.00

STEP 4: SPOUSE OR DEPENDENT COVERAGE INFORMATION: Dependent children up to age 26 are eligible for coverage.

First Name: _____
Last Name: _____

Gender:
☐ Male
☐ Female

Date of Birth: ___/___/_____
MM DD YYYY

SSN (Required for insurance purposes):

First Name: _____
Last Name: _____

Gender:
☐ Male
☐ Female

Date of Birth: ___/___/_____
MM DD YYYY

SSN (Required for insurance purposes):

STEP 5: PAYMENT CHOICE: *(Please select one)*

I hereby apply for the coverage indicated, and understand that the premium payment is for 12 months of coverage and is not refundable for any reason. If I do not renew my contract at the end of the 12 months, I cannot re-enroll for 36 months. I further understand that my enrollment is subject to receipt of payment in the correct amount. If a check is returned for any reason, a $20.00 fee will be charged. Dental monthly payment option includes a $20.00 processing fee.

☐ **Convenient Monthly Bank Draft** – REFER TO REVERSE FOR MONTHLY RATES.
INCLUDE A CHECK FOR THE "FIRST MONTH RATE" MADE PAYABLE TO PISI AND COMPLETE INFORMATION BELOW
Routing Number (9 digit): _ _ _ _ _ _ _ _ _ Account Number: _____
If you do not include the first month's payment with this application, PISI will debit the above account at the time your application is processed.

I (we) authorize and request PISI to initiate electronic debit entries to my (our) account indicated on this form in the financial institution named on this form ("BANK"). I (we) authorize and request BANK to honor the debit entries initiated by PISI and debit these charges to that account. This authorization will remain in effect until all amounts owed related to the contract are paid in full, or until I (we) cancel this authorization. To cancel this monthly withdrawal I (we) must notify PISI and BANK in writing 60 days in advance to give PISI and BANK a reasonable opportunity to act. Cancellation of this electronic debit authorization does not cancel the terms of the Dental/Vision contract, I am agreeing to pay the full annual Dental/Vision premium. **I understand that the funds will be withdrawn on the 10th of each month** and that it is my responsibility to ensure sufficient funds are in my account at that time. If the 10th of the month falls on a weekend or holiday, PISI will initiate a debit entry on the next business day. If more than 2 withdrawals in a 12 month period are denied for any reason I understand I risk cancellation of my Dental/Vision Benefits.

☐ **Annual Payment:** Please make your check payable to PISI.

▶ _____ _____
Please sign as acknowledgement of above Date

For office use only Eff Date: _____ Cust ID: _____ DW: _____ VW: _____

DENTAL MONTHLY PREMIUMS

	First Month's Check	Eleven Monthly Withdrawals	Annual Totals
INDIVIDUAL	$39.23	$39.07	$469.00*
TWO PARTY	$72.49	$72.41	$869.00*
FAMILY	$111.24	$111.16	$1,334.00*

*A $20 fee is charged to pay the dental premium monthly. The figures shown are what will be deducted from your account.

VISION MONTHLY PREMIUMS - STANDARD PLAN

	First Month's Check	Eleven Monthly Withdrawals	Annual Totals
INDIVIDUAL	$6.24	$6.16	$74.00
TWO PARTY	$10.99	$10.91	$131.00
FAMILY	$15.87	$15.83	$190.00

VISION MONTHLY PREMIUMS - ENHANCED PLAN

	First Month's Check	Eleven Monthly Withdrawals	Annual Totals
INDIVIDUAL	$7.50	$7.50	$90.00
TWO PARTY	$13.50	$13.50	$162.00
FAMILY	$20.87	$20.83	$250.00

PARSE CHAPTERS

1 - 10	Blair, Bedford, Huntington
1 - 20	Central Penn (Adams, Cumberland, Dauphin, Juanita, Mifflin, Perry, York)
1 - 25	Franklin
1 - 27	Fulton
1 - 30	Lancaster, Lebanon
1 - 40	Mt. Nittany (Centre, Clinton)
1 - 50	MUNS (Montour, Union, Northumberland, Snyder)
2 - 10	Endless Mts. (Bradford, Sullivan, Susquehanna, Lycoming, Tioga)
2 - 20	Lackawanna, Wyoming
2 - 30	Luzerne, Columbia
2 - 50	Schuylkill, Carbon
2 - 60	Wayne, Pike, Monroe
3 - 10	Erie
3 - 20	Jefferson, Clearfield
3 - 27	Crawford
3 - 30	McKean, Potter, Cameron, Elk
3 - 40	Venango, Clarion, Mercer
3 - 50	Barton Schuler (Warren, Forest)
4 - 10	Berks, Lehigh, Nortthampton
4 - 30	Delaware, Chester
4 - 50	Montgomery
4 - 60	Philadelphia, Bucks
5 - 10	Cambria, Somerset
5 - 20	Indiana, Armstrong
5 - 30	West SICO (Westmoreland, South Indiana)
5 - 40	West Penn (Allegheny, Beaver, Butler, Fayette, Greene, Lawrence, Washington)
5 - 50	Laurel Highlands (Somerset)
6 - 20	Member-At-Large (No Chapter Affiliation, Out-of-State Members)

ENROLLMENT INFORMATION

1. Complete steps 1-5 on this enrollment form.
2. Unmarried dependent children can be enrolled up to age 26. Disabled dependent children can be enrolled to any age.
3. Mail your completed Application and payment to PISI at 3913 Hartzdale Drive Suite 1300, Camp Hill PA 17011. ***Applications must be received by the 20th of a month to become effective the 1st of the following month. Your coverage will run for a 12-month period from your effective date.**
4. You will receive identification information from United Concordia and/or Davis Vision. ID cards will be issued in the policyholder's name but can also be used by spouses/dependents on the plans.
5. These benefits are available to fully paid members of PARSE. Membership must be maintained in order for you to access the dental/vision policies. Membership to PARSE is based on a calendar year.

If you have any questions on enrollment please contact PISI at 1 (800) 382-1352