



## TWU Local 252 – Active & Retired Members 2019 Enrollment Form

### SECTION 1: Your Information *(Please Print Clearly)*

First Name:		Last Name:	
Street Address:			
City:	State:	Zip Code:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Date of Birth (MM/DD/YY):		Social Security Number (XXX-XX-XXXX):	
Email Address:		Phone #:	

### SECTION 2: Your Coverage Selection

	CIGNA DENTAL DMO	GVS VISION/HEARING	Dentist Office Code: _____
YOURSELF ONLY	<input type="checkbox"/> \$20.75	<input type="checkbox"/> \$13.50	<i>Go to <a href="http://www.cigna.com">www.cigna.com</a> to locate a provider or call 800-244-6224. If you do not choose a Dentist, Cigna will assign one to you and you can change it by contacting Cigna.</i>
YOU + SPOUSE	<input type="checkbox"/> \$35.75	<input type="checkbox"/> \$22.50	
YOU + CHILD(REN)	<input type="checkbox"/> \$46.00	<input type="checkbox"/> \$23.00	
FAMILY	<input type="checkbox"/> \$65.50	<input type="checkbox"/> \$34.00	

### SECTION 3: Your Dependents *(Dependent Children are covered to the end of the month they turn 26.)*

	First Name	Last Name	Gender (M/F)	Date of Birth (MM/DD/YY)
Spouse				
Dependent				
Dependent				

### SECTION 4: Your Monthly Payment Information

Payment is taken on the 28<sup>th</sup> of each month by Extensive Benefits (Union Insurance)

***You must pay with VISA, MasterCard, Discover, American Express, Debit Card or Automatic Withdrawal from Checking Account.***

Account Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Credit or Debit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

M M Y Y

Checking Account: Bank Name: \_\_\_\_\_



Routing Number (9 digits)

Account Number

I hereby authorize Extensive Benefits to charge insurance premiums to my credit/debit card indicated in this authorization form. This payment is for vision and/or hearing insurance monthly premiums, underwritten by Cigna and/or GVS. My signature and date on this form certifies and warrants that all dependent eligibility information is true, correct and current.

Signature \_\_\_\_\_

Date \_\_\_\_\_

#### RETURN THIS FORM TO:

Email: [INFO@extensivebenefits.com](mailto:INFO@extensivebenefits.com)

Fax: 404-585-3508

Mail: Extensive Benefits, Inc.

1266 W Paces Rd #655

Atlanta, GA 30327

If you have any questions regarding the coverage options, please contact

**CIGNA (Dental) (PLAN NAME: TWU LOCAL 252) – 800-244-6224**

**GVS (Vision) (PLAN NAME: EXTENSIVE BENEFITS) – 877-547-6957**

**GHS (Hearing) (PLAN NAME: EXTENSIVE BENEFITS) – 888-899-1447**

For billing questions, contact Extensive Benefits at 888-416-4211