PSEACare Dental & Vision Enrollment Change Form

Check all that apply: **Address Change** ___ **Add Dependent Coverage** ___ **Drop Dependent Coverage** ___ **Terminate All Coverage** ___

Member's Information:

Name: _____

Address: _____

City: _____ *State*: ____ *Zip Code*_____

PSEA ID or SSN # _____

Birthdate: ____ /____ / ____ *Telephone* ( ) _____

Effective Date of change : _____

Spouse's Information: (check one) **Drop**____ **Add** _____

Name: _____ *Gender:* __ Male __ Female

Social Security # _____ *Birthdate:* ___ /____ / _____

Dependent's Information: (check one) **Drop**____ **Add** _____

Name: _____ *Gender:* __ Male __ Female

Social Security # _____ *Birthdate:* ___ /____ / _____

Dependent's Information: (check one) **Drop**____ **Add** _____

Name: _____ *Gender:* __ Male __ Female

Social Security # _____ *Birthdate:* ___ /____ / _____

PAYMENT OPTIONS

Monthly Rates:	Individual	$44	Annual Rates:	Individual	$ 522
	Two-Party	$88		Two-Party	$1,044
	Family	$132		Family	$1,566

I certify the statement made herein is complete and true to the best of my knowledge and belief.

_____

Signature Date

Questions? Please contact us at
1-800-944-7732
Ext. 7024

Please send check payable to:
PSEA Health and Welfare Fund
PO Box 1724
Harrisburg PA 17105-1724

HWF Use Only:
*Carrier:*_____
*ACH:*_____

MONTHLY ACH PAYMENT AUTHORIZATION

PSEACare premiums are established each 12-month contract period by the Pennsylvania State Education Association Health & Welfare Fund ("Fund") Trustees and are subject to change at each renewal.

If monthly election, I understand that by signing on the reverse side, I am authorizing monthly charges from the checking account provided to the Fund for my PSEACare premium. This charge will be reflected as a debit on the regular account statement for the checking account provided. I further understand that the amount of these premiums may change at the end of each 12-month contract year and that the amount debited from my account for the PSEACare premium may also change to match the premium rate. **Payments will be deducted on or about the 15th of each month.**

I understand that although I am making monthly payments, I am responsible for all twelve (12) months of the PSEACare premium for the coverage I have elected. If I wish to stop participating in PSEACare, I must notify the Fund no less than thirty (30) days before the date of my annual contract renewal. (*For example, assume that your annual contract renewal date is July 1. You must notify the Fund on or before June 1 that you do not wish to continue to participate in PSEACare.*)

I agree to notify the Fund in writing of any changes to my account information at least fifteen (15) days in advance of the scheduled payment date. I understand that if the scheduled payment date falls on a weekend or holiday, the payment may be executed on the next business day. Further, I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the scheduled payment date.

If the ACH transaction is rejected by my bank for non-sufficient funds ("NSF"), I authorize the Fund, at its discretion, to reprocess the charge again no more than thirty (30) days later than the initial charge. In addition, I agree to remit all NSF charges for each attempt that was returned "NSF." The Fund will recoup any bank charges incurred for the "NSF" transaction and its recovery through an electronic charge that is separate from the regular monthly charge for your premium.

I understand that if there are insufficient funds to pay the PSEACare premium and the Fund has attempted to seek electronic payment, the Fund may discontinue my coverage under PSEACare if I fail to make alternative arrangements with the Fund within 15 days of the original ACH charge for the payment of my premium.

I agree not to dispute the premium charge listed above with my bank provided the premium charge is consistent with the information agreed to in this Form. I release the Fund from any claim, demand, or liability relating to the information that I provide. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.