



## PSEACare Dental & Vision Enrollment Form

### Member's Information:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
 SSN # \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
 Birthdate: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

### Spouse's Information (if enrolling spouse):

Name: \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female  
 Social Security # \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

### Dependent's Information (if enrolling dependent up to age 26):

Name: \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female  
 Social Security # \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

### Effective Date for Benefit coverage contract period (please circle one):

January 1, 2018    March 1, 2018    May 1, 2018    July 1, 2018  
 September 1, 2018    November 1, 2018

### Dependent's Information (if enrolling dependent up to age 26):

Name: \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female  
 Social Security # \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

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

Signature

### 2018/19 PAYMENT OPTIONS

Monthly Rates: Individual	\$39	Annual Rates: Individual	\$463
Two-Party*	\$78	Two-Party*	\$926
Family*	\$117	Family*	\$1,389

Note: Monthly premium rates include a \$5 per participant per year processing charge.

\* Includes dependent children up to age 26 or any age with certified disability.

Please Choose Payment Option: (Please check one) Monthly \_\_\_\_\_ Annual \_\_\_\_\_

**If you choose to pay monthly, please complete and sign the ACH Payment Authorization form on the back on this page.**

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.

When signing up for the ACH payments, please send a check in the amount of the first month’s payment. The submitted check will be used to make the first month’s payment and will be the account from which all future payments will be made via ACH. ACH payments will begin in the first month of the benefit period.

**Please send completed enrollment form (front side of this page), this ACH Authorization, and check payable to:**

PSEA Health and Welfare Fund  
P.O. Box 1724  
Harrisburg PA 17105-1724

*Questions? Contact us at 1-800-944-7732 ext. 7024*

**2017/18 Check amount for first month’s payment: Individual \$39 or Two-Party \$78 or Family \$117**

**I authorize the PSEA Health & Welfare Fund to make automatic deductions from my checking account for the PSEACare monthly payments. \_\_\_\_\_ (please initial)**

I understand that by initialing above, 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 15<sup>th</sup> 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.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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