Dental Plan

MetLife

Endorsed by
MEMBER BENEFITS
nysut
Working to Benefit You

THE DENTAL PLAN

The Dental Plan endorsed by the NYSUT Member Benefits Trust,* which features the MetLife PDP Plus Network, offers easy-to-understand dental coverage that allows you to:

Protect — you and your family by providing competitively priced dental coverage for most preventive and routine services that help promote long-term oral health.

Choose — the dentist of your choice at the time of treatment. You do not have to select a primary dentist; there's no ID card to show or referrals needed for specialty care.

Save** — on out-of-pocket expenses by receiving services from thousands of participating dentist locations nationwide that agree to charge fees typically 30% to 45% lower than the average charges in your area.***

With the MetLife Dental Plan, featuring the PDP Plus network, you receive a wide range of benefits that provide choice, savings** and convenience to help make your dental health a priority.

If you have any questions after reading this benefit overview, please visit the NYSUT Member Benefits website at **memberbenefits.nysut.org** and click on "Dental Plan" under the "Insurance" tab in the menu at the top of the homepage. From there, you will find a "Dental Plan" program page containing more information, including how to find participating dentists, how to enroll online and other program specifics. You can also call MetLife toll-free at **888-883-0046.**

Please Note: You may already have dental coverage provided to you through your local association. If not, you may wish to consider this plan when choosing your coverage.

HOW THE DENTAL PLAN WORKS

The Dental Plan, underwritten by MetLife, pays benefits for three categories of service: Type A — Preventive, Type B — Basic Restorative and Type C — Major Restorative. (Please reference the section titled "Primary Covered Services" for examples of these services.)

* Coverage is provided under a group insurance policy (Policy form G.2130-S) issued by MetLife.

** Savings from enrolling in the Dental Plan will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

The plan also offers you a choice; you may use a **participating** dentist (**in-network**) or you may use an out-of-network dentist. If you choose **to receive services from a participating** dentist, you will generally incur the least out-of-pocket expense.

If you use a participating dentist, the plan provides paid-in-full benefits for Type A services.[1] You will have out-of-pocket costs for Type B and Type C services provided by participating dentists.

If you use an out-of-network dentist, you generally will have higher out-of-pocket costs for all types of services.

There is an annual benefit maximum of $2,500 per person under this plan for covered services rendered by participating dentists and by non-participating dentists.

IN-NETWORK BENEFIT

When you or your eligible dependent visit a participating dentist, plan benefits are based on a negotiated fee schedule. You will be responsible for the difference between the negotiated fee*** for a given service and the percentage of the fee that your plan covers for that service, subject to any deductibles.

Benefit Summary:	**Plan Coverage:**
Type A — Preventive	100% of Negotiated Fee***
Type B — Basic Restorative	60% of Negotiated Fee***
Type C — Major Restorative	35% of Negotiated Fee***

Annual Deductible:	**Amount:**
Individual	$50
Family	$100

Deductibles only apply to Type B and C Benefits

Annual Maximum Benefit: $2,500/person

[1] Subject to frequency limitations.

*** Negotiated fees refers to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated Fees are typically 15% to 45% below community averages. Negotiated fees are subject to change.

PRIMARY COVERAGE SERVICES*

Coverage	Type of service	How often
A — Preventive	Cleanings	• 1 every six months, not to exceed two per calender year
	Exams	• 1 every six months, not to exceed two per calender year
	Fluoride Treatments	• 1 per calendar year for dependent children up to 14th birthday
	X-rays	• Full mouth X-rays: one per 60 months • Bitewing X-rays: 1 set per calendar year
B — Basic Restorative	Fillings, Amalgam or Resin	• When dentally necessary
	Simple Extractions	• When dentally necessary
	Labs and Other Tests	• When dentally necessary
	Space Maintainers	• For dependent children up to 19th birthday
	Periodontic Maintenance	• Total number of periodontal maintenance treatments and prophylaxis cannot exceed four in a calendar year
	Crown, Denture, Bridge Repair	• When dentally necessary
	Endodontics	• Root canal treatment limited to once per tooth per 24 months
C — Major Restorative	Surgical Extractions	• When dentally necessary
	General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services
	Oral Surgery	• When dentally necessary
	Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months
	Relines and Rebases	• Relines and rebases to dentures, limited to 36 months (covered only after six months following the initial installation)
	Crowns/Inlays/Onlays	• Crowns/Inlays/Onlays replacement: 1 in 84 months
	Bridges and Dentures	• Initial placement to replace one or more natural teeth that are lost while covered by the plan • Dentures and bridgework replacement: once every 10 years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
	Implants	• Implants, 1 in 84 months
	Bruxism	• Bruxism, 1 in 24 months

OUT-OF-NETWORK BENEFIT

When you or your eligible dependent visit a non-participating dentist, **plan benefits are based on the Reasonable and Customary (R&C) fee.**** You will be responsible for the difference between your dentist's charge for a given service and the percentage of the Reasonable and Customary fee that your plan covers, subject to any deductibles.

Annual Maximum Benefit: $2,500/person

Benefit Summary:	**Plan Coverage:**
Type A — Preventive	100% of R&C Fee**
Type B — Basic Restorative	60% of R&C Fee**
Type C — Major Restorative	35% of R&C Fee**

Annual Deductible:	**Amount:**
Individual	$50
Family	$100

Deductibles apply only to Type B and C Benefits

* The types of services shown illustrate representative services within each coverage type. Please refer to your insurance certificate for a complete list and description of covered services.

** R&C fee refers to the Reasonable and Customary fee, which is based on the lowest of 1. the dentist's actual charge, 2. the dentist's usual charge for the same or similar services or 3. the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

** R&C fee refers to the Reasonable and Customary fee, which is based on the lowest of 1. the dentist's actual charge, 2. the dentist's usual charge for the same or similar services or 3. the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

ELIGIBILITY REQUIREMENTS

You must be a NYSUT In-Service or Retiree member at the time of your enrollment to be eligible for the Dental Plan (underwritten by MetLife).

Coverage is also available for your spouse (or certified domestic partner[1]) and your dependent children. Unmarried, dependent children are covered until the end of the month of their 26th birthday.

Once you obtain coverage, there are options for you and your covered dependents to continue coverage should your NYSUT membership lapse. In addition, there are continuation options for your covered children when they are no longer eligible to be covered under your plan, as well as options for your covered dependents should you die or become divorced or legally separated.

MONTHLY RATES

The following monthly rates are effective through December 31, 2022:

Member Only — $51.20 per month

Member + One — $114.04 per month

Member + Family — $142.05 per month

PAYMENT METHOD

Select your payment method by completing the attached "Authorization Agreement for Dental Insurance Payments" form. You can select from:

- In-Service Members Only: Payroll Deductions
- Retired Members Only: Automatic monthly pension deduction (available if you are collecting a monthly pension benefit from the NYSTRS, NYSERS, NYCTRS, or NYCBERS, or if you are receiving income from a monthly lifetime annuity from TIAA).
- If you select payroll or pension deduction, there are no service fees.

[1] A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the Member, Associate Member, or Retired Member.

Payroll deduction is available in local associations that have made the necessary payroll deduction arrangements for NYSUT Member Benefits-endorsed programs.

The following direct billing options apply to both In-Service and Retired Members:

- Direct billing: $6.00 service fee per billing cycle for quarterly billing (4 payments per year); $9.00 service fee per billing cycle for semi-annual billing (2 payments per year); or $12.00 service fee per billing cycle for annual billing (1 payment per year).
- ACH: You will charged a $6.00 service fee per billing cycle for quarterly billing; $9.00 service fee per billing cycle for semi-annual billing; or $12.00 service fee per billing cycle for annual billing.
- Semi-annual direct billing: You will be charged a $9.00 service fee per billing cycle for semi-annual billing (two payments per year).
- Annual direct billing: You will be charged a $12.00 service fee per billing cycle for annual billing (one payment per year).

IMPORTANT ENROLLMENT PROVISIONS

1. Coverage for all members and eligible dependents who enroll in this dental program will become effective on the first of the month following the date your application was received and accepted.
2. You may change coverage only when you have a Qualifying Event that changes your family status (e.g., marriage, divorce, the birth or adoption of a child, death of a dependent, termination of your spouse's employment, etc.). You may enroll or change your enrollment option for coverage within 30 days of the above Qualifying Events.
3. **If you leave the program, you will not be permitted to re-enroll.**

30-DAY FREE LOOK

After receiving your confirmation of acceptance in the plan, if you are not satisfied with the terms of your new coverage and no claims have been submitted/paid, simply return the confirmation to the Plan Administrator within 30 days of receipt, and any money you have paid will be refunded in full with no questions asked. Any claim submitted (subsequent to or before disenrollment) by a participant who disenrolls will be denied (including claims by any dependents of the participant).

COORDINATION OF BENEFITS

The Dental Plan contains a Coordination of Benefits clause that may reduce the dental expense benefits payable by the amount of benefits payable from another group, employer or government-sponsored plan.

CERTIFICATE OF INSURANCE

Please use the Dental Plan link from **memberbenefits.nysut.org** to link to MetLife's MyBenefits, where you can view a copy of the Dental Plan Certificate. The Certificate will describe all benefits, conditions, exclusions, and limitations. Please read your Certificate carefully.

ANSWERS TO YOUR QUESTIONS

How do I enroll?

There are two easy ways to enroll:

4. **Online:** Visit **metlife.com/NYSUTdental** and click on "Enroll."
5. **By Mail:** Simply fill out the enrollment authorization and other applicable forms in the center of this brochure.

What is a participating dentist?

A participating dentist is a general dentist or specialist who meets MetLife's strict credentialing standards* and agrees to accept negotiated fees for covered services. There are thousands of participating dentist and specialist locations nationwide.

How do I find a participating dentist?

The MetLife Dental Plan endorsed by the NYSUT Member Benefits Trust features the PDP Plus network, giving you access to thousands of participating dentist locations nationwide. To conduct an online provider search, visit **benefits4dental.com/nysut** and select Dentist Search under "View Your Plan." You can also call MetLife for assistance toll-free at **888-883-0046**, Mon.–Fri., 8 a.m.–11 p.m. (EST).

* Certain providers may participate with MetLife through an agreement that MetLife has with a vendor. Providers available through a vendor are subject to the vendor's credentialing process and requirements, not MetLife's. If you should have any questions, contact MetLife Customer Service.

How are claims paid?

Filing a claim is simple. Complete the patient portion of your claim form and your dentist should complete the rest. Either you or your dentist can submit the claim to MetLife for processing. You will receive an explanation of benefits statement showing charges and payments. Benefits will be paid to you unless you have assigned payment to your dentist.

How do I file a claim?

Claim forms can be downloaded and printed by using the "Dental Plan" link on the Member Benefits website at **memberbenefits.nysut.org**, or you can call MetLife toll-free at **888-883-0046**.

Submit claims to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

COVERED BENEFITS LIMITATIONS

The fact that a dentist recommends a dental service does not mean dental expense benefits will be paid under the Dental Plan. Dental expense benefits will be based on the most cost-effective materials and methods of treatment that meet generally accepted dental standards.

MetLife's dental consultants may review dental services to determine whether the dental service is necessary in terms of generally accepted dental standards for the purpose of determining the extent to which dental expense benefits are payable under the Dental Plan.

PROGRAM EXCLUSIONS*

This plan does not cover the following services, treatments and supplies:

1) Temporomandibular joint disorders (TMJ)
2) Those received before coverage begins
3) Those not performed by a dentist, except cleaning and scaling of teeth and fluoride treatments performed by a licensed dental hygienist whose work is supervised and billed by a dentist
4) Cosmetic services, surgery or supplies
5) Services or supplies that are covered by any workers' compensation laws, occupational disease laws or employer's liability laws, or which an employer is required by law to furnish in whole or in part
6) Those that are received through a medical department or similar facility maintained by your employer
7) Home health aids used to prevent decay, such as toothpaste and fluoride gels
8) Duplicate appliances or duplicate prosthetic devices
9) Services or supplies received by a covered person, where no charge would have been made in the absence of dental expense benefits, or which are not required to be paid
10) Materials or services that are experimental under generally accepted dental standards
11) Received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while coverage is in effect
12) Instruction for oral care such as hygiene or diet
13) Periodontal splinting
14) Benefits otherwise provided under your employer's plan or any other plan that your employer or an affiliate contributes to or sponsors
15) Charges by the Dentist for missed appointments or for completing dental forms.
16) Sterilization supplies
17) Furnished by a family member

* Please refer to your benefits certificate for a complete list and description of program exclusions and limitations.

18) For Type C Expenses: 1) Replacement of a lost, missing or stolen crown, bridge or denture 2) Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started 3) Replacement of an existing crown, removable denture or fixed bridgework unless it is needed because the existing crown, denture or bridgework can no longer be used and was installed at least 10 years prior (five years for crowns) to its replacement 4) Replacement of existing immediate temporary full denture by a new permanent full denture unless: (a) the existing denture cannot be made permanent; and (b) the permanent denture is installed within 12 months after the existing denture was installed 5) Adjustment of a denture or bridgework that is made within six months after installation by the same Dentist who installed it
19) Orthodontia
20) Sealants
21) Temporary or provisional restorations
22) Temporary or provisional appliances
23) Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan that the Policyholder (or an affiliate) contributes to or sponsors

METLIFE PRIVACY NOTICE

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan sponsors and group insurance contract holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting your information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting your information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates or other companies. Our affiliates include life, car and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

How we get your information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense,

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. (MIB), a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB toll-free at **866-692-6901** or by contacting MIB at **www.mib.com**.

Using your information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- process claims and other transactions
- perform business research
- confirm or correct your information
- market new products to you
- help us run our business
- comply with applicable laws

Sharing your information with others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company — even one of our affiliates—for their own marketing purposes. If you have dental, long-term care or medical insurance from us, the Health Insurance Portability and Accountability Act (HIPAA) may further limit how we may use and share your information. You may obtain a copy of our HIPAA Privacy Notice by visiting our website at **www.MetLife.com**. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at **HIPAAprivacyAmericasUS@metlife.com**

Accessing and correcting your information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing, listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
MetLife Insurance Company of Connecticut
General American Life Insurance Company
SafeGuard Health Plans Inc.
SafeHealth Life Insurance Company

metlife.com

MetLife has approved the content relating only to MetLife products listed on this advertisement. MetLife makes no representations with respect to NYSUT membership or the benefits thereof.

The MetLife Dental Plan is a NYSUT Member Benefits Trust (Member Benefits)–endorsed program. Member Benefits has an endorsement arrangement of 5% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

Like most group benefit programs, MetLife group benefit programs contain certain exclusions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife for complete details.

If there is a conflict between this brochure and the group insurance policy, including the certificate, the group policy will govern.

Metropolitan Life Insurance Company | 200 Park Avenue, | New York, NY 10166
L1220009938[exp0122][All States][DC,GU,MP,PR,VI]

MetLife

LOCAL 1741

Authorization Agreement for Dental Insurance Payments

You have four convenient ways to pay your dental insurance premiums: Pension Deductions from your monthly pension benefit, Payroll Deductions, Direct Billing or ACH.

Please check one, complete the information requested below and return this form with your enrollment form:

☐ **Monthly Pension Deduction** – for Retired Members only, for pension benefits*
☐ **Payroll Deduction** – for In-Service Members only

Direct Bill**
☐ Quarterly Direct Bill
☐ Semi-Annual Direct Bill
☐ Annual Direct Bill

ACH**
☐ Quarterly Direct Bill
☐ Semi-Annual Direct Bill
☐ Annual Direct Bill

**You must complete and sign the two sided form attached in order to begin pension deductions.*
***Direct Bill and ACH options include service fees per billing cycle detailed on page 6 of this brochure.*

Do not send any payments now. You will be billed at a later date.

Please mail this completed form to P&A along with your enrollment form to:
P&A Group, Attn - Group Insurance Services Department, 17 Court Street, Suite 500, Buffalo, NY 14202

NYSUT MEMBER BENEFITS PENSION DEDUCTION AUTHORIZATION

NYSUT Member Benefits Trust | NYSUT Member Benefits Corporation | NYSUT Member Benefits CMM Insurance Trust

Last Name_____ First _____ Middle Initial_____

Address_____

Phone ( )_____ NYSUT ID (seven-digit) # _____

Authorization is for_____ Soc. Sec. #_____
(name of plan/insurance)

Please Note: You must be retired for a minimum of six months to be eligible for pension deduction.

Read statements on the reverse side. Signature and date are required.*

Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.

2K, 9/19, I-106

NYSUT MEMBER BENEFITS PAYROLL DEDUCTION AUTHORIZATION

NYSUT Member Benefits Trust | NYSUT Member Benefits Corporation | NYSUT Member Benefits CMM Insurance Trust

(Please Print):

Last Name_____ First_____ Middle Initial_____

Address_____ NYSUT ID #_____

Home Phone # _____Member's SS #_____

I hereby authorize my employer to deduct from each of my salary checks the deductions necessary for the purpose of NYSUT Member Benefits. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity. For insurance plans, I understand that this authorization may be revoked at any time by written notice to the Plan Administrator. For plans with annual fees, I understand that I must provide written notice to the Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee.

Signature of Employee_____ Date_____

Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.

Please check your union membership affiliation:

❒ *UFT* ❒ *UUP* ❒ *PSC/CUNY** ❒ *All other NYSUT Locals*

The amount of deductions will be determined by NYSUT Member Benefits based on the programs chosen, and may be adjusted to ensure that premiums are paid in full.

**This authorization card cannot be used to authorize deductions for PSC-CUNY Welfare Fund Benefits.*

1.5K, 5-16 I-05

The MetLife Dental Plan is a NYSUT Member Benefits Trust (Member Benefits)- endorsed program. Member Benefits has an endorsement arrangement of 5% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. Member Benefits acts as your advocate; please contact Member Benefits at 800- 626- 8101 if you experience a problem with any endorsed program.

Like most group health insurance policies, MetLife group policies contain certain exclusions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife for complete details.

If there is a conflict between this brochure and the group insurance policy, including the certificate, the group policy will govern.

CHECK ONE BOX ONLY - SIGN AND DATE BELOW

☐ I belong to the Teachers' Retirement System of the **CITY of New York** (TRS) and I hereby request a monthly withholding of deductions from my monthly benefit for the purchase of union-sponsored benefits as permitted by Chapter 248, Laws of 1994.

☐ I belong to the New York City Board of Education Retirement System (BERS).

☐ I belong to the NYSUT Staff Pension Program.

☐ I belong to the New York **STATE** Teachers' Retirement System (NYSTRS), or

☐ I belong to the New York **STATE** Employees' Retirement System (NYSERS) and I hereby request monthly withholding of union deductions from my monthly benefit as permitted by Section 536 of the Education Law and Section 110-C of the Retirement Social Security Law.

NYSERS #:_____

☐ I am a TIAA participant and hereby request a monthly withholding of deductions from my TIAA monthly lifetime annuity income for the purchase of coverages provided through NYSUT Member Benefits' Pension Advantage program. If at any time the total deductions equal or exceed my combined monthly income payments from TIAA, all deductions I have authorized TIAA to take on my behalf will terminate immediately.

I expressly acknowledge and understand that - 1. Deductions will continue until the appropriate Plan Administrator receives written notice from me to the contrary; 2. NYSUT Member Benefits will determine the exact deductions to be withheld monthly and any questions regarding the amount will be directed by me to NYSUT Member Benefits; 3. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity as referenced on the reverse side; 4. For insurance plans, I understand this authorization may be revoked at any time by written notice to the appropriate Plan Administrator; 5. For plans with annual fees, I understand that I must provide written notice to the appropriate Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee. I hereby certify to the NYCTRS, NYSTRS, NYSERS or TIAA that I am a member of NYSUT, an employee organization entitled to receive union deduction payments as provided by law.

***Signature**_____ ***Date**_____

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Association		Group Customer #	Report #	Sub Code	Branch
NYSUT Member Benefits Trust [1]		**105643**			
Date of Membership (MM/DD/YYYY)	NYSUT ID #	Coverage Effective Date (MM/DD/YYYY)			Source Code

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)		Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

Dental Insurance

Select your level of coverage

- ☐ Member Only
- ☐ Member + One Dependent (Spouse/Domestic Partner or Child)
- ☐ Member + Two or More Dependents (Spouse/Domestic Partner and Children)

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

[1] The MetLife Dental Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits receives an amount equal to five percent (5%) of the gross annual premium for this program from MetLife. Such payments to Member Benefits are used to defray the costs of administering the program. Member Benefits acts as your advocate. Please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

GEF02-1
ADM

SUBMISSION INSTRUCTIONS

After completion, sign and date the form on the last page where indicated.
Make a copy for your records and return the original to P&A, Dental Plan Administrator,
17 Court Street, Suite 500, Buffalo, NY 14202-9922.

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

GEF09-1
FW

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC

SUBMISSION INSTRUCTIONS

After completion, **sign and date the form where indicated.**
Make a copy for your records and return the original to P&A, Dental Plan Administrator,
17 Court Street, Suite 500, Buffalo, NY 14202-9922.