United Concordia
Dental Application

PLEASE PRINT CLEARLY.

Please see other side on how to apply...

APPLICANT

Social Security Number – –	Last Name	First	M.I.

Street Address	Telephone ( )

City	State	Zip	Sex ☐M ☐F	Birth Date (Mo/Day/Yr) / /

Email ☐ **YES** *I would like to receive Paperless correspondence and/or Renewal Invoices via email*

COVERAGE DESIRED & ANNUAL PREMIUMS *(Please ✔ one)*

Premiums include a Third Party Administration fee.

☐ Individual (Applicant Only) **$498**	☐ Two-Party (Applicant Plus One) **$909** *enter information below*	☐ Family (Applicant Plus Two or More) **$1,398** *enter information below*

FAMILY MEMBERS - DEPENDENTS

	Social Security No.	Last Name	First	M.I.	Sex M/F	Birth Date Mo/Day/Yr	Disabled Yes/No
Spouse							
For disabled dependent children age 26 or older call 1-800-382-1352 for a Dependent Certification form.							
Child							
Child							
Child							

PAYMENT METHOD

☐ ***Enclosed Check/Money Order (please make check payable to "PISI")***

☐ ***Monthly Payment (please complete enclosed authorization form)***

Credit Card: ☐ ***MasterCard*** ☐ ***Discover*** ☐ ***Visa***

Card No. ______________________ *Exp. Date* __________ *CVV Code** __________

*Three digit code on back of card

____

Cardholder's Name, as it appears on Credit Card

____

Cardholder's Address (if different from applicant)

X ______________________________ **X** __________

Signature (for Credit Card authorization only) *Date*

Important—Please read and sign below: *Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information or conceals for the purposes 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.*

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 due to insufficient funds, a $20.00 fee will be charged.

X ______________________________ **X** __________

Applicant's Signature ***Date***

HOW TO APPLY:

1. To apply for Dental coverage, complete this Application.
2. Check the Coverage you desire: **Individual; Two-Party** (member and spouse or member and child); or **Family** (member plus two or more dependents). Unmarried dependent children can be enrolled up to age 26, disabled dependents to any age. ***If enrolling a disabled dependent age 26 or older please call 1-800-382-1352 for a Dependent Certification form which must be completed and returned with your application.***

ANNUAL DENTAL PREMIUMS	
Individual	**$498**
Two-Party	**$909**
Family	**$1,398**

3. Full annual premiums can be submitted for the type of coverage you choose. You may pay by personal check, money order or MasterCard, Visa or Discover credit card. (If paying by credit card, please ensure that you complete the credit card information requested on the application). Checks are to be made payable to "PISI".
4. Monthly premiums can be paid from your checking account. If you would like to pay the premium monthly, please complete the enclosed "authorization for monthly withdrawal" form.
5. Mail the fully completed Application(s) and your payment using the enclosed postage-paid envelope to: PISI (Administrator), 2 Kacey Court, Suite 102, Mechanicsburg PA 17055. **If your Application(s) and payment are received at PISI by the 20th of the current month, the coverage will become effective the first of the following month**.
6. To confirm your effective date, please call PISI at 1-800-382-1352. You will receive ID cards from United Concordia for your plan titled "PISI".

IMPORTANT NOTICE:

The Missouri State Teachers Association (MSTA) endorses PISI's United Concordia Dental Plan for those who are PAID members of MSTA and their eligible dependents.

MSTA routinely checks membership records to assure compliance. Either you or your spouse must be a PAID Member of MSTA to enroll or renew your dental coverage.