TEAMSTERS LOCAL UNION 282

January, 2021

RETIREE DENTAL INSURANCE ENROLLMENT

Dear Union Retiree:

Thank you for your service with the Teamsters Local Union 282!

Teamsters Local Union 282 is excited to be able to offer you and your family three Dental Insurance plans through Cigna. Two of the Dental plans are DHMOs, which means you MUST see a Cigna In-Network Dentist and one of the plans is a DPPO, which means you can see any dentist, but you receive higher savings if you see an in-network DPPO dentist. To locate a dentist provider, contact Cigna at 800-244-6224 or go to www.cigna.com.

Monthly Premiums	**Cigna In-Network Only DHMO (K1-09)**	**Cigna In-Network Only DHMO (A2109)**	**Cigna In and Out-of-Network DPPO**
Yourself Only	$15.25	$21.00	$41.50
Yourself and Spouse	$25.50	$37.00	$79.75
Yourself and Child(ren)	$30.75	$46.25	$90.00
Family	$43.50	$66.50	$140.00

If you decide to enroll in a plan, you must charge it on a Credit Card, Debit Card or have it automatically withdrawn from your checking account each month by Extensive Benefits, Inc. (Union Insurance will appear on your monthly statement).

To enroll, please complete the attached Enrollment Form and return to Extensive Benefits. Your Dental insurance will be effective the first of the month after we receive your Enrollment Form. *(See the Enrollment Form for additional information on where to return the form)*

For questions regarding the plan designs, claims or locating a provider, please contact Cigna at 800-244-6224. For billing questions, contact Extensive Benefits at 888-416-4211 or email your questions to info@extensivebenefits.com.

Again, we are glad to be able to offer you these benefit programs and will continue to review our Retiree Benefits to best serve you and your family.

Regards,
Thomas Gesualdi, President
Local 282 IBT
2500 Marcus Ave
Lake Success, NY 11042
Telephone: (516) 488-2822 Long Island
(718) 343-3322 New York

RETIREE DENTAL ENROLLMENT FORM
for TEAMSTERS LOCAL UNION 282

Your Information *(Please Print)*

First Name: Last Name:

Street Address:

City: State: Zip Code: Gender: ☐ F ☐ M

Date of Birth (MM/DD/YY): Social Security Number (XXX-XX-XXXX):

Email: Phone:

Your Monthly Rate and Coverage Options

	CIGNA IN-NETWORK ONLY DHMO (K1-09)	CIGNA IN-NETWORK ONLY DHMO (A2109)	CIGNA IN AND OUT OF NETWORK DPPO
Yourself Only	☐ $15.25	☐ $21.00	☐ $41.50
You and Your Spouse	☐ $25.50	☐ $37.00	☐ $79.75
You and Child(ren)	☐ $30.75	☐ $46.25	☐ $90.00
Family	☐ $43.50	☐ $66.50	☐ $140.00

Your Dependent Information (Dependents are eligible until the end of the month of their 26th birthday.)

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

Your Monthly Payment Information

Payment is taken on the 28th 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.

☐ **Credit or Debit Card Number:** **Expiration Date:**

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ___ ___ - ___ ___

M M Y Y

☐ **Checking Account:**

_____ _____

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 Dental insurance monthly premiums, underwritten by CIGNA. 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:

Mail: **Extensive Benefits, Inc.**
1266 W Paces Ferry Rd #655
Atlanta, GA 30327

Email: **INFO@extensivebenefits.com**
Fax: **404-585-3508**
Phone: **888-416-4211**