DRL
Doyle Rowe LTD

PLEASE READ BEFORE COMPLETING YOUR DELTA DENTAL FORM

Dear PDRMA Retiree:

Thank you for your interest in the PDRMA endorsed Delta Dental plan. The following will assist you in completing the enrollment materials:

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM:
ALL GROUPS MUST COMPLETE THIS SECTION: This section is for office use only. Please leave this section blank.

EMPLOYEE/DEPENDANT/ADDITIONS/TERMINATIONS/CHANGES: Check the box "Yes, I want to enroll in the dental plan offered by Delta Dental of Illinois." Next, check the box labeled "Delta Dental PPO/Delta Dental Premier", and continue to the social security number line. Please supply social security number, employee's name, mailing address, marital status, date of birth and male or female.

REASON FOR SUBMITTING THIS FORM: Please check the box, "Initial or Open Enrollment."

COVERAGE DESIRED: please select the appropriate coverage type. Note: for the purpose of this form only, retirees are considered the employee.

PLEASE LIST ALL ELIGIBLE DEPENDANTS TO BE COVERED: please complete if applicable.

YOUR SIGNATURE IS REQUIRED AT THE BOTTOM OF THE APPLICATION.

HEALTH CARE PROGRAM PREMIUM DEDUCTION AUTHORIZATION:
Please complete the information at the top of the form and check the Delta Dental of Illinois for yourself and if applicable, your spouse or family. You and your spouse (if applicable) must sign the form.

PLEASE NOTE: The Delta Dental plan requires a one year enrollment commitment.
2017 Single Premium is $56.78, Single +1 premium is $113.57 and Family premium is $177.19. Coverage will begin on the first of the month following receipt of your application (if received before the 15th of the month). These rates are guaranteed through December 31, 2017.

Please complete the Delta Dental Enrollment form and the Health Care Program Premium Deduction Authorization form and return to:
Doyle Rowe, LTD, 1301 W. 22nd St. Suite 101, Oak Brook, IL 60523.

Please contact our office at 1-877-845-1793 with any questions.

Sincerely,

Doyle Rowe LTD

PDRMA healthprogram

Providing Health Benefits and Tools for Healthier Living

Dear PDRMA Member Retiree:

As a retiree or spouse of a retiree (age 65 and over) of a PDRMA member agency you are eligible to enroll in a quality, affordable group dental plan underwritten by Delta Dental.

Highlights of the plan include:

Individual Annual Maximum	**$1,800 per member**
Deductible	**$25 per person/$75 per family** **Does not apply to Diagnostic/Preventive Services**
Diagnostic/Preventive Services Includes: Oral Exams (two per benefit year) Dental Prophylaxis (two per benefit year) X-rays	**100%**
Basic Restorative Includes: Amalgam fillings Posterior composite fillings Simple extractions Complex oral surgery including general Anesthesia	**80%**
Endodontics	**80%**
Periodontics	
Non-Surgical	**80%**
Surgical	**50%**
Major Restorative Includes: Crowns, inlays, onlays, Post and core, bridges and dentures, Implants	**50%**

2017 Monthly Premiums (One year enrollment is required)

Single	**$56.78**
Single + One	**$113.57**
Family	**$177.19**

Monthly premiums may be deducted from your Illinois Municipal Retirement Fund benefit check.

Doyle Rowe LTD's qualified staff is also available to assist PDRMA member retirees with Medicare supplement plans underwritten by Blue Cross and Blue Shield of Illinois. These plans are available to Illinois residents aged 65 and older with Medicare Parts A & B. To learn more about the plans and to enroll contact the **Doyle Rowe LTD PDRMA Retiree Group Information line at 1-877-845-1793.**

Sincerely,

The PDRMA Health Program

P.O. Box 4320
Wheaton, IL 60189
Phone: 630-435-8998 • Fax: 630-769-0125

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

DELTA DENTAL

PLEASE KEEP A COPY FOR YOUR FILES. ***Please note that completing this form does not guarantee coverage.***

ALL GROUPS MUST COMPLETE THIS SECTION Note: Incomplete forms will be returned.

Delta Dental Group Number 10979 Sublocation Number _____ ☐ Salaried ☐ Hourly

Effective Date _____ Date of Hire _____ OR Date of Rehire _____ ☐ Non-Union ☐ Union

Name of Employer _____ Location/Department _____ ☐ Other _____

Group Contact _____

Group Contact Phone _____ Group Contact Email _____

EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

☐ **Yes,** I want to enroll in the dental plan offered by Delta Dental of Illinois. (Please select a network below.)

☐ Delta Dental PPO/Delta Dental Premier If applicable: ☐ High Option ☐ Low Option

☐ DeltaCare DHMO (please complete the section below)

Dentist Name _____ Address _____ Facility Code _____

☐ DeltaCare DHMO Dentist Change (please complete the section below)

Dentist Name _____ Address _____ Facility Code _____

☐ **No,** I do not want to enroll in the dental plan offered by Delta Dental of Illinois. *(If you are declining, please write your name below and sign at the bottom of this form.)*

Social Security Number _____ Employee's Name _____
(First Name MI Last Name)

Alternate ID # _____ # Hours Worked _____ Job Title _____

Mailing Address _____
(Street City State Zip)

Email Address _____ Phone Number _____

Marital Status: ☐ S ☐ M ☐ Other Date of Birth ____/____/____ ☐ Male ☐ Female

REASON FOR SUBMITTING THIS FORM

☐ Initial or Open Enrollment ☐ COBRA COBRA End Date ____/____/____ ☐ Retiree

☐ Reinstatement due to: ○ Rehire ○ Loss of Other Coverage ○ Other _____

☐ Add Dependent (list below) due to:

○ Birth ○ Adoption ○ Marriage ○ Loss of Other Coverage ○ Legal Guardianship ○ Disabled Dependent

○ Military Dependent ○ Other _____ Date of Qualifying Event ____/____/____

☐ Drop Dependent (list below) due to:

○ Age ○ Death ○ Divorce ○ Other Coverage Elsewhere Date of Qualifying Event ____/____/____

☐ Termination of Employment Date ____/____/____ ☐ Covered Under Spouse Date ____/____/____

☐ Name Change (Former Name _____) ☐ Address Change

COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & One Child ☐ Employee & Children ☐ Entire Family

Is spouse covered under another dental plan? ☐ Yes ☐ No Other Carrier Name _____

Are dependents covered by spouse's plan? ☐ Yes ☐ No Spouse's Carrier _____

Spouse's Employer _____

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/mm/yyyy)	SEX (M or F)
☐	☐	1. Spouse:			
☐	☐	2. Child:			
☐	☐	3.			
☐	☐	4.			
☐	☐	5.			

I agree to continue membership in this program until the next open enrollment period and authorize payroll deduction where applicable.

Signature of Applicant _____

Health Care Program Premium Deduction Authorization for IMRF-endorsed Plans

IMRF Form 7.10E (Rev. 08/2013)

- Please indicate which program you are **NEWLY** applying for by checking the appropriate box(es) below.
- Fill out the front page of this form only; the back page will be filled out by the plan administrator.
- **Please note**: All programs except for Sav-Rx **require additional applications.**
- **Return completed form to**: Doyle Rowe Ltd.,1301 W. 22nd Street, Suite 101, Oak Brook, IL 60523.
- **If you have any questions contact Doyle Rowe at 1-800-564-7227 or www.doylerowe.com.**

PLEASE PRINT OR TYPE

MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	IMRF MEMBER ID OR LAST 4 DIGITS OF SSN

(If applicable) SPOUSE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
	_____ - _____ - _____

HOME STREET (MAILING) ADDRESS	

CITY, STATE, AND ZIP	DAYTIME TELEPHONE NUMBER (with Area Code)
	( )

To be completed by applicant. Please note that all programs except Sav-Rx require a separate application form. CHECK ONLY THE PLAN YOU ARE NEWLY ENROLLING IN.

Seniors Choice	☐ Individual	☐ Spouse	**Humana Local PPO**	☐ Individual	☐ Spouse	
United Health Care Medicare Complete	☐ Individual	☐ Spouse	**Humana Regional PPO**	☐ Individual	☐ Spouse	
Health Care Alliance HMO	☐ Individual	☐ Spouse	**Humana Group PDP Plan**	☐ Individual	☐ Spouse	
Health Care Alliance PPO	☐ Individual	☐ Spouse	**Sav-Rx Advantage Card**	☐ Individual	☐ Spouse	
Blue Cross Blue Shield of Illinois	☐ Individual	☐ Spouse	**Delta Dental of Illinois**	☐ Individual	☐ Spouse	☐ Family
Blue Cross Blue Shield of Texas	☐ Individual	☐ Spouse	**United Health Care Vision Plan**	☐ Individual	☐ Spouse	☐ Family

Member Authorization

I authorize and request the Illinois Municipal Retirement Fund (IMRF) to deduct premiums for the selected program(s) from my IMRF benefit payment and to remit the amount deducted to the health care program. I authorize IMRF to release information to the health care program in order to ensure proper handling of premiums. I understand IMRF will adjust deductions in response to changes in the premiums. I further understand that IMRF will cease making any deduction if the premiums exceed my IMRF benefit amount. This authorization is not an assignment of my right to receive payment. This authorization will remain in effect with IMRF until cancelled by written notice from me or until IMRF is notified that a premium deduction is no longer required.

MEMBER SIGNATURE* DATE (MM/DD/YYYY) SPOUSE'S SIGNATURE DATE (MM/DD/YYYY)

***Member signs if member is receiving benefit payment; Spouse signs if spouse is receiving surviving spouse benefit or if spouse is enrolling in the Sav-Rx Advantage Card program.**

FOR IMRF USE ONLY	Date Entered	Date Effective