If you are not currently enrolled in the Union's Dental/Vision Insurance, or the Union's Voluntary Life Insurance, and wish to do so, fill out the enclosed documentation and return to the Union Office one of three ways:

1. **Deliver in person to the Union Office**
2. **Fax to the Union Hall at (901) 386-3105**
3. **Mail to the Union Office at 5150 Stage Rd, Suite 103, Memphis, TN 38134**

This must be received no later than November 30, 2020. No exceptions.

If you are an active employee and enrolled in the city's dental/vision, you must de-enroll no later than October 31 if you wish to de-enroll from the city's plan. No exceptions. (You are allowed to have both the city and union dental/vision if you so choose.)

Questions can be directed to the Union Office at (901) 386-3129.

2021 Local 1784 Insurance Comparison

	Union Dental/Vision The Standard Ins Company		City Dental/Vision Blue Cross/Blue Shield	
Dental Benefits	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Deductible (On Basic & Major Services Only)	Individual: $50 Family: $150	Individual: $50 Family: $150	Individual: $50 Family: $150	Individual: $50 Family: $150
Annual Maximum Benefit	$1,250.00		$1,500.00	$1,500.00
Preventive Services Exams, Cleanings, X-Rays	100%	100%	100%	80% Employees & Spouses eligible for a $25 gift card after showing proof of one cleaning per year
Basic Services Fillings, General Anesthesia, Surgery, Simple Extractions	90%	80%	80%	60%
Major Services Crowns, Bridges, Dentures, Inlays, Veneers	60%	50%	50%	40%
Orthodontia	50% to a Lifetime Max of $1,000		50% to a Lifetime Max of $1,000	
Waiting Periods	No Waiting Period		No Waiting Period	
Network Name	Classic PPO		BCBS Dental	
Vision Benefits	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Exams	Once Every 12 Months	Covers Up to $35	$15 Copay One every 12 months	Covers Up to $45
Deductible	$10	$0	$0	$0
Lenses	Once Every Rolling 12 months		Once Within A 12 Month Period	
Single Vision	Covered in Full	Up to $25	$15 Copay	Up to $40
Bifocal	Covered in Full	Up to $40	$15 Copay	Up to $65
Trifocul	Covered in Full	Up to $55	$15 Copay	Up to $75
Lenticular	20% Discount	Not Covered	$15 Copay	Up to $100
Contact Lenses	Once every rolling 12 months		Limited to one set of lenses every calendar year	
Conventional Contact Lenses	$150 Allowance	Up to $105	$150 Allowance	Up to $120
Disposable Contact Lenses	$150 Allowance	Up to $105	$150 Allowance	Up to $120
Medically Necessary Contacts	$0 Copay	Up to $225	Covered at 100%	Up to $210
Frames	Up to $150 Once Every Rolling 24 months	Up to $75	$0 copay up to $150 Allowance	Up to $82
Network Name	EyeMed		BCBS Vision	
Dental/Vision Premium (Per Payday)				
Single	$16.51		$12.18	
Member + One	$32.53		$24.79	
Family (Employee + Two Dependents)	$49.68		$37.40	

Basic/Group Life - $10,000 Life Insurance to all Local 1784 Members free of charge, regardless of active or retired or age

Voluntary Life Insurance	**$20,000**	**$3.42 per pay period**
(Member Life Insurance)	**$50,000**	**$8.55 per pay period**
Voluntary Life Insurance	**$10,000**	**$1.50 per pay period**
(Spousal Life Insurance)	**$25,000**	**$3.75 per pay period**

(Must purchase member life in order to purchase spousal life)

DENTAL/VISION INSURANCE ELECTION FORM

_____ I wish to enroll in the dental/vision insurance from IAFF Local 1784
(Please fill out the enclosed enrollment form and payroll deduction form)

_____ I wish to de-enroll from the dental/vision insurance from IAFF Local 1784
(Please fill out the enclosed CANCEL form)

_____
Member's Signature

_____
Date

_____ I wish to purchase the voluntary life insurance on myself (this is in addition to the $10,000 insurance the union provides to me as a part of my membership)

_____ I choose the $20,000 life insurance on myself ($3.42 per pay period)

_____ I choose the $50,000 life insurance on myself ($8.55 per pay period)

_____ I choose to decline (or de-enroll from) the voluntary life insurance on myself at this time. I understand I can enroll at a later time during open enrollment.

_____ I wish to purchase life insurance on my spouse (**the voluntary life insurance on yourself must be selected in order to enroll in the spousal and/or child life insurance)**

_____ I choose the $10,000 coverage on my spouse ($1.50 per pay period)

_____ I choose the $25,000 coverage on my spouse ($3.75 per pay period)

_____
Spouse's Name

_____
Spouse's Social Security Number

_____
Spouse's Date of Birth

_____ I choose to decline (or de-enroll from) the life insurance on my spouse at this time. I understand I can enroll at a later time during open enrollment.

_____ I choose to purchase life insurance on my child(ren) **(the voluntary life insurance on yourself must be selected in order to enroll in the child and/or spousal life insurance)**

_____
Child's Name

_____
Child's Social Security Number

_____
Child's Date of Birth

_____ I choose to decline (or de-enroll from) the life insurance on my child(ren) at this time. I understand I can enroll at a later time during open enrollment.

_____ _____

Member's Signature **Date**

Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
759590	**Memphis Fire Fighters**		

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

☐ Add Dependent ☐ Delete Dependent Date of Add/Delete _____

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **Memphis Fire Fighters Association - Local 1784**	Hours Worked Per Week		
Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Your Full Name

Dental Insurance

☒ Dental (Employee paid)

Are you or your dependents covered for dental insurance under another plan? ☐ Yes ☐ No

Eye Care Insurance

☒ Balanced Eye Care (Employee Paid)

Are you or your dependents covered for eye care insurance under another plan? ☐ Yes ☐ No

List dependents to enroll or drop for Dental and/or Eye Care, if applicable. (Attach sheet for additional dependents, if needed.)

Full Name (Last name if different, First, Middle Initial)	Dental (Employee paid)		Eye Care (Employee paid)		Gender		Date of Birth
	Add	Drop	Add	Drop	M	F	
Spouse	☐	☐	☐	☐	☐	☐	
Child 1	☐	☐	☐	☐	☐	☐	
Child 2	☐	☐	☐	☐	☐	☐	
Child 3	☐	☐	☐	☐	☐	☐	

Dental and/or Eye Care Insurance Waiver: Dental and/or Eye Care Insurance

The insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the insurance coverage may be subject to a Late Entrant Penalty.

I decline ☐ Dental and/or ☐ Eye Care insurance for myself.

I decline ☐ Dental and/or ☐ Eye Care insurance for one or more dependents.

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Signature of Applicant (Member/Employee)	Date

Member's Personal Email Address:_____

Authorization for Payroll Deduction
Memphis Fire Fighters Association
IAFF Local 1784

I, the undersigned, hereby designate IAFF Local 1784 as my duly chosen and authorized representative on matters relating to my employment. I further request and authorize the deduction from my earnings each payroll period an amount sufficient to provide for the regular payment of the current rate of monthly union dues and benefits established by the union. This authorization may be terminated by me by giving the Union and City a thirty (30) day written notice in advance, by execution of a cancellation form or upon termination of my employment.

It is further understood and agreed that if I violate the covenant not to strike I shall hold the city of Memphis harmless from any and all liabilities or claims which it may incur or sustain as a result of my violation of the covenant not to strike.

Please Print
Name_____
Last First Middle Initial

Address_____
Number/Street City Zip Telephone

Dept. – Fire Division 13

Employee ID # ☐☐☐☐☐☐☐☐☐

All Amounts Listed Are Per Pay Period

(Check all that may apply)

A. Union Dues..... $26.76 ☒

B. Dental & Vision Insurance – **Standard Insurance**

Employee Only..... $16.51 ☐

Employee + 1..... $32.53 ☐

Family..... $49.68 ☐

C. Optional **Employee** Hartford Life Insurance ($20,000)....$3.42 ☐ ($50,000)…. $8.55 ☐

D. Optional **Spouse** Hartford Life Insurance ($10,000)....$1.50 ☐ ($25,000)…. $3.75 ☐

E. Optional Dependent **Child(ren)** Hartford Life Insurance ($10,000/child)..... $0.49 ☐

Signature: _____ **Date:** _____

09/21/20

Memphis Fire Fighters Association

IAFF Local 1784

Life Insurance Beneficiary Form

Name: _____ Employee ID #: _____

Address: _____

Email Address (personal, not city): _____

Cell Phone: _____ Last 4 digits of SSN: _____

Date of Birth: _____ FD Work Assignment (or Retired): _____

The sum of all primary beneficiaries must total 100% and the sum of any/all contingent beneficiaries must total 100% (e.g. allocation of three primary beneficiaries could be 34%, 33%, 33%).

PRIMARY BENFICIARY DESIGNATION

Name (Last, First)	Phone Number	Relationship	Date of Birth	Share %

Applies To: _____ Group Life _____ Voluntary Life _____ Both Group Life & Voluntary Life

CONTINGENT BENFICIARY DESIGNATION

Name (Last, First)	Phone Number	Relationship	Date of Birth	Share %

Applies To: _____ Group Life _____ Voluntary Life _____ Both Group Life & Voluntary Life

Signature: _____ Date: _____

3/2019 (MJT)