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 October 21, 2022. No exceptions.

If you are an active employee and enrolled in the city's dental/vision, you must de-enroll no later than October 21 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.

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..... $30.62 ☒

B. Union 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:** _____

09/16/21