If you are not currently enrolled in the Union's Dental/Vision 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, 2023. No exceptions.

If you are a retiree and enrolled in the city's dental/vision, you must de-enroll no later than NOVEMBER 3rd 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 choose.)

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

2024 IAFF Local 1784 Insurance Comparison

	Union Dental/Vision Cigna		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	$10 Copay One Every 12 Months	Covers Up to $45	$15 Copay One every 12 months	Covers Up to $45
Deductible	$0	$0	$0	$0
Lenses	Once Every 12 months / $10 Copay		Once Within A 12 Month Period	
Single Vision	Covered in Full	Up to $32	$15 Copay	Up to $40
Bifocal	Covered in Full	Up to $55	$15 Copay	Up to $65
Trifocul	Covered in Full	Up to $65	$15 Copay	Up to $75
Lenticular	Covered in Full	Up to $80	$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 $120	$150 Allowance	Up to $120
Disposable Contact Lenses	$150 Allowance	Up to $120	$150 Allowance	Up to $120
Medically Necessary Contacts	$0 Copay	Up to $210	Covered at 100%	Up to $210
Frames	Up to $150 Once Every Rolling 24 months	Up to $83	$0 copay up to $150 Allowance	Up to $82
Network Name	EyeMed		BCBS Vision	
Dental/Vision Premium (Per Payday)				
Single	$16.33		$12.19	
Member + One	$32.19		$24.79	
Family (Employee + Two Dependents)	$49.13		$37.43	

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

Cigna Dental and Vision Enrollment Form

Employer: Complete Section A
Employee: Complete Sections B, C & D

Insured and/or Administered by
Cigna Health and Life Insurance Company

Cigna.

Please print and thank you for providing this information

A

☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS

CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	DENTAL BENEFIT OPTION	VISION BENEFIT OPTION

TYPE OF CHANGE:

- ☐ **Add Dependent(s) *** Date: _____
- ☐ **Cancel Employee** Last Date of Coverage: _____
- ☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
  Reason for Cancellation:
  - ☐ Leave employment
  - ☐ Transfer out of Cigna Dental Care area
  - ☐ Transfer to another plan
- ☐ **Address Change**
- ☐ **Transfer to COBRA**
  - ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ **Other** _____

*** List Names in Section C**

B

EMPLOYEE NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NO.

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE	WORK PHONE	HOME E-MAIL ADDRESS	EMPLOYEE IDENTIFICATION NUMBER
	( )	( )		

ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*

WHAT IS YOUR PRIMARY LANGUAGE? *(optional)*	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? *(optional)* ☐ Yes ☐ No	SELECT PLAN: ☐ Cigna Dental Care® ☐ Cigna Dental EPO ☐ Cigna Vision ☐ Cigna Dental PPO ☐ Cigna Traditional

C

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	FULL-TIME STUDENT? Yes No	DENTAL OFFICE SELECTION *(for Cigna Dental Care only)*	START DATE OF CONTINUOUS DENTAL COVERAGE *(for Cigna Dental PPO only)* *(Month, Day, Year)*	*(check one)*
Employee			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel

Proof of student or handicapped status for overage dependents may be required.
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

D

SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE / DATE

NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.

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.

Please Print

Name_____
Last First Middle Initial

Address_____
Number/Street City Zip

Telephone _____

Dept. – Fire Division 13 (**Retired**)

Employee ID Number (or Last Four of Social Sec Number) _____

All Amounts Listed Are Per Pay Period

(Check all that may apply)

A. Union Dues..... $ 15.00 ☐

B. Union Dental Insurance – Cigna Insurance Company

	HMO	**PPO**
Employee Only.....	$ 11.44 ☐	$16.33 ☐
Employee + 1.....	$ 22.50 ☐	$32.19 ☐
Family.....	$ 34.59 ☐	$49.13 ☐

C. Optional Life Insurance (NCPERS) ..... $ 6.00 ☐

Signature_____ Date_____

(ver10242023mjt)

Memphis Fire Fighters Association
IAFF Local 1784
Life Insurance Beneficiary Form

Name: _____ Employee ID #:_____

Complete Address: _____

Personal Email Address: _____

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% or 25%, 25%, 25%, 25%)

PRIMARY BENEFICIARY DESIGNATION

Name	Phone Number	Relationship	Date of Birth	Share (%)

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

CONTINGENT BENEFICIARY DESIGNATION

Name	Phone Number	Relationship	Date of Birth	Share (%)

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

Signature: _____ Date: _____

2/21 (MJT)