DENTAL SERVICE CENTER
Dental and Vision Care Plans
Post Office Box 3901 • Gardena, CA 90247-7599
888•293•4903 • DentalServiceCenter@ngfcu.us

Dental & Vision Care Plans
Offered by:
NORTHROP GRUMMAN FEDERAL CREDIT UNION

Welcome to the 2024-2025 Dental and Vision Care plan Enrollment Season!

Did you know you can get quality, affordable, **dental and vision coverage** for yourself and your family? Children can now be on your plan until age 26 with no student verification. Just enroll in any of the options below during this annual, limited renewal and open enrollment period. Submit your completed applications by **June 14, 2024**, for your coverage to take effect on **July 1, 2024.** If you have questions, call us at **888.293.4903.**

Choose a dental care plan from CIGNA and vision care coverage through VSP

• Maximize savings with the CIGNA Dental Care® (DHMO) plan

Why pay more than you should for dental care? The CIGNA DHMO plan has comprehensive coverage, including orthodontic coverage for both children and adults. With the DHMO plan, you choose a primary dentist from the network at enrollment. Specialty care is available with a referral approved for payment. No deductibles, no claim forms, no annual maximums! Keep in mind, there is no out-of- network coverage with a DHMO plan. **Finding a DHMO network dentist is easy!** Search online at **cigna.com** or call for live customer service - 24/7 - at **800.CIGNA24** (800.244.6224) using our plan **ID 3214092.**

• Balance freedom and savings with the CIGNA Dental PPO Advantage (DPPO) plan

As a DPPO customer, you may visit any licensed dentist, with no referrals required for specialty care. Choosing a CIGNA **Advantage Network dentist (or specialist)** will save you money on your dental bills because CIGNA Advantage Network dentists agree to offer discounts to CIGNA customers. In addition, they cannot charge you more than their contracted rates for covered services. **Finding an Advantage Network dentist is easy!** Search online at cigna.com or call for live customer service - 24/7 - at **800.CIGNA24** (800.244.6224) using our plan **ID 3214092.**

• Vision Service Plan (VSP) Choice Plan:

VSP is the largest vision care provider in the United States, with over 71,000 access points. Visit **vsp.com** or call 800.877.7195 to locate a provider.

Inside this kit, you will find plan details, rates, payment options and enrollment forms for the Dental and Vision Care Plan options. Be sure to read the enclosed plan materials carefully before making a decision.

When you're ready to enroll, complete the enrollment form(s) for the coverage you want to have and use the enclosed envelope to return your form(s) to us. You must complete **separate enrollment forms** to enroll for both dental and vision coverage. Payments can be easily made by phone (debit, credit or ACH) or send a check in the mail. Checks must be payable to "**Dental Service Center**". You can send your first quarterly payment, or your entire annual premium amount. **We must receive your enrollment form(s) and check(s) no later than June 14, 2024 for coverage to begin on July 1, 2024.** Please Note: If you cancel during the 1st year of enrollment there is NO opportunity for reinstatement. If you cancel after the 1st year, there is a 2-year wait for reinstatement.

*If you are requesting this kit **after** our initial open enrollment deadline, there are **pro-rated** rates and enrollment deadlines for the time you are requesting. **NO enrollment during the last quarter of the plan year (April May June).** Please see the rate sheet for details.*

Questions? Call us toll-free at **888.293.4903.**

To your good health,

The Dental Service Center Team

Cigna®

Important Information About Selecting a Cigna Dental Plan

Compare Plan features & Monthly Premiums!*

CIGNA Dental Care (HMO) New

Patient Charge Schedule **P5I0X**
Minimize out-of-pocket expenses!

- Finding a **Dental Care network** dentist is easy: Call a representative at 800.CIGNA24 (800.244.6224) or use the dental office locator at cigna.com
- No claim forms to file
- No deductibles to meet, so your coverage starts right away.
- No Annual dollar maximums, so you don't have to postpone any treatment.
- Set copays for services
- Access to a large credentialed national network of independent dentists.
- Specialty care available, with a referral approved for payment.
- Out-of-network benefits are not available with the CIGNA Dental Care plan.

CIGNA Dental PPO

Visit any licensed dentist!

- Finding an Advantage network dentist is easy: Call a representative at 800.CIGNA24 (800.244.6224) or use the dental office locator at cigna.com
- Save on out of pocket expenses for treatment when you visit any provider in our large national PPO Advantage network, offering the deepest discounts.
- Also, save on out of pocket expenses by visiting a provider in the "CIGNA DPPO network". These providers offer discounts (less deep than offered by Advantage provider), at the out-of-network benefit level.
- In-network or not, you'll be reimbursed for all or part of the cost for covered services up to your annual dollar maximum, after meeting your deductible.
- Out of pocket expenses will be higher when you visit a non-network dentist.
- Most network dentist file claim forms for members; members must file claims for out-of-network care.
- No referral necessary to see a specialist. Fast, accurate, convenient claims processing.

Monthly Rate*	CIGNA Dental Care (HMO)	CIGNA Dental PPO
Member Only	**$26.74**	**$53.00**
Member + One	**$52.71**	**$88.00**
Member + Family	**$73.63**	**$131.00**

* Monthly rates are for comparison only. Premiums are paid annually or quarterly. Please refer to the Rate sheet included.

A LOOK AT YOUR VSP VISION COVERAGE

vsp℠ Vision care for life

See Healthy and Live Happy with Help from VSP.

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

Value and Savings You Love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

Provider Choices You Want.

It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations — including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

PREMIER PROGRAM Visionworks

Quality Vision Care You Need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. This comprehensive eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using Your Benefit Is Easy!

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

ENROLL TODAY.

Contact us: 800.877.7195 or vsp.com

NORTHROP GRUMMAN FEDERAL CREDIT UNION

Dental and Vision Care Plan Rates

Cigna. VSP Vision care for life

- Child must be under the age of 26 and student verification is no longer required.
- Rates are payable **annually** by full payment or **quarterly** by automatic checking or savings account deductions (ACH). **Any** returned Check or ACH is subject to a $20.00 fee (See agreement below).
- **When quarterly automatic deductions are elected, the first quarterly payment for each coverage plan selected must be made with a separate check (payable to the Dental Service Center) submitted with each signed enrollment form.**
- To cancel coverage, written notice must be received by the Dental Service Center no later than the **5th** of the month **prior** to the month the coverage will terminate.

Please Note: If you cancel during the 1st year of enrollment there is **NO** opportunity for reinstatement. If you cancel after the 1st year, there is a 2-year wait for reinstatement.

You must enroll for the full plan year through June 30, 2025.

Send your completed enrollment form(s) and separate check(s) by June 14, 2024.

CIGNA Dental HMO P5I0X

No dental offices in the following states: AK, DE, HI, ID ,ME, MT, ND, NH, NM, PR, RI, SD, VT, WV, WY

Payment Options:	Quarterly	Annual
Member Only	**$80.22**	**$320.88**
Member + One	**$158.13**	**$632.52**
Member + Family	**$220.89**	**$883.56**

CIGNA Dental Preferred Provider Organization (PPO) Advantage Networks

Available in all states. NOTE: The $50 deductible and $2,000 in-Advantage Network or $1,500 out-of-network maximum is based on the plan year.

Payment Options:	Quarterly	Annual
Member Only	**$159.00**	**$636.00**
Member + One	**$264.00**	**$1,056.00**
Member + Family	**$393.00**	**$1,572.00**

VSP Vision Care Plan Choice Plan

Available in all states.

Payment Options:	Quarterly	Annual
Member Only	**$38.52**	**$154.08**
Member + One	**$59.73**	**$238.92**
Member + Family	**$86.07**	**$344.28**

Authorization Agreement for Quarterly Automatic Checking or savings Account Deductions – By enrolling in any of the dental or vision care plans above, I indicate the following:

- I have a checking account at the financial institution named on the enclosed check and, for all debit entries, shall have funds sufficient to pay such entries. Electronic debit entries shall be initiated by Dental Service Center to pay dental and/or vision plan costs and other charges for the coverage plans selected and the entries shall constitute my receipt for the transaction(s).
- No payment to Dental Service Center shall be deemed to have been made unless and until Dental Service Center received actual credit. I also understand that if corrections of the entry are necessary, it may involve an adjustment to my account.
- **I understand my direct electronic payment of the premium due will be debited on or about the 5th day of each month prior to the following calendar quarter for which premium is due. (For example, the April-May-June quarterly premium will be deducted from my account on the 5th of March.)**
- Dental Service Center reserves the right to refund or terminate electronic payment services. This agreement is to remain in effect until Dental Service Center terminates it or receives written notification from the enrollee to terminate participation in the plan and Dental Service Center has sufficient time to act upon the request.

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Recurring ACH Payment Authorization

I authorize Dental Service Center to deduct subsequent quarterly payments from my account referenced below. I have read and agree to the Authorization Agreement. **I understand future deductions will be taken the 5th of each month prior to the following calendar quarter for which premiums is due. (For example, the October, November, December quarterly premium will be taken on the 5th of September.)**

I _____ authorize the Dental Service Center to charge my
(Full Name)

account indicated below for $ _____ on the 5th of the following months,
(Amount $)

June, September, December, March.

FINANCIAL INSTITUTION DETAILS

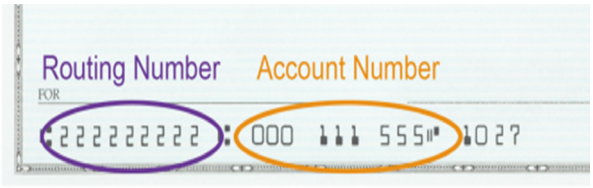
☐ Checking ☐ Savings

Account Holder Name _____

Financial Institution Name _____

Routing Number _____

Account Number _____



Authorization Agreement for Quarterly Automatic Checking or savings Account Deductions – By enrolling in any of the dental or vision care plans, I indicate the following:

- I have an account at the financial institution named above and, for all debit entries, shall have funds sufficient to pay such entries. Electronic debit entries shall be initiated by Dental Service Center to pay dental and/or vision plan costs and other charges for the coverage plans selected and the entries shall constitute my receipt for the transaction(s).
- No payment to Dental Service Center shall be deemed to have been made unless and until Dental Service Center received actual credit. I also understand that if corrections of the entry are necessary, it may involve an adjustment to my account.
- **I understand my direct electronic payment of the premium due will be debited on or about the 5th day of each month prior to the following calendar quarter for which premium is due. (For example, the April-May-June quarterly premium will be deducted from my account on the 5th of March.)**
- Dental Service Center reserves the right to refund or terminate electronic payment services. This agreement is to remain in effect until Dental Service Center terminates it or receives written notification from the enrollee to terminate participation in the plan and Dental Service Center has sufficient time to act upon the request.

SIGNATURE

Signature	Date

NORTHROP GRUMMAN FEDERAL CREDIT UNION

Dental Plan Application

SELECT THE PLAN THAT'S RIGHT FOR YOU **PLEASE PRINT**

1. (check one) ☒ CIGNA DPPO ☐ CIGNA DHMO* Advantage Network

*Please choose a dental office from the website **cigna.com** or 800.244.6224. Dental Office Code No._____

2. I am enrolling (check one): ☒ Myself only ☐ Myself + One ☐ Myself + Family Coverage to begin:_____

LIST ONLY THE MEMBERS WHO ARE TO BE INSURED BELOW

NAME FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
ADDRESS:			
CITY:		STATE:	ZIP:
PHONE:	EMAIL:	DATE OF BIRTH:	☐ MALE ☐ FEMALE

SPOUSE FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
DATE OF BIRTH:	☒ MALE ☐ FEMALE		

To list more children, enclose information on a separate sheet of paper. **Child must be under the age of 26.**

CHILD 1 FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
DATE OF BIRTH:	☐ MALE ☐ FEMALE	☐ STUDENT	☐ DISABLED
CHILD 2 FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
DATE OF BIRTH:	☒ MALE ☐ FEMALE	☐ STUDENT	☐ DISABLED
CHILD 3 FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
DATE OF BIRTH:	☐ MALE ☐ FEMALE	☐ STUDENT	☐ DISABLED

3. CHOOSE A PAYMENT OPTION – SEPARATE CHECKS REQUIRED FOR EACH ENROLLMENT FORM

☒ Annual Check – Enclosed is my annual payment made payable to: **Dental Service Center**

☐ Quarterly Automatic Deduction - **Please complete the DSC Recurring ACH Payment Authorization.**

4. I accept the coverage/insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverage as indicated on this form. I authorize any participating dental office to release dental records and billing information to CIGNA Dental Health for purposes of plan administration.

5. I understand that if I cancel this coverage, I must do so in writing and submit it by the 5th of the month prior to the effective cancellation month date. I must wait 2 years before I can re-enroll.

6. New Enrollees may not cancel during the initial plan year.

AUTHORIZED SIGNATURE _____ DATE _____

NORTHROP GRUMMAN FEDERAL CREDIT UNION

Vision Care Plan Application

SELECT THE PLAN THAT'S RIGHT FOR YOU **PLEASE PRINT**

1. I am enrolling (check one): ☐ Myself only ☐ Myself + One ☐ Myself + Family Coverage to begin: _____

LIST ONLY THE MEMBERS WHO ARE TO BE INSURED BELOW

NAME FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
ADDRESS:			
CITY:		STATE:	ZIP:
PHONE:	EMAIL:	DATE OF BIRTH:	☐ MALE ☐ FEMALE

SPOUSE FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
DATE OF BIRTH:	☐ MALE ☐ FEMALE		

To list more children, enclose information on a separate sheet of paper. **Child must be under the age of 26.**

CHILD 1 FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
DATE OF BIRTH:	☐ MALE ☐ FEMALE	☐ STUDENT	☐ DISABLED
CHILD 2 FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
DATE OF BIRTH:	☐ MALE ☐ FEMALE	☐ STUDENT	☐ DISABLED
CHILD 3 FIRST:	LAST:	MIDDLE INITIAL:	SOCIAL SECURITY/TIN:
DATE OF BIRTH:	☐ MALE ☐ FEMALE	☐ STUDENT	☐ DISABLED

2. CHOOSE A PAYMENT OPTION – SEPARATE CHECKS REQUIRED FOR EACH ENROLLMENT FORM

☐ Annual Check – Enclosed is my annual payment made payable to: **Dental Service Center**

☐ Quarterly Automatic Deduction - **Please complete the DSC Recurring ACH Payment Authorization.**

3. I accept the coverage/insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverage as indicated on this form. I authorize any participating dental office to release dental records and billing information to CIGNA Dental Health for purposes of plan administration.

4. I understand that if I cancel this coverage, I must do so in writing and submit it by the 5th of the month prior to the effective cancellation month date. I must wait 2 years before I can re-enroll.

5. New Enrollees may not cancel during the initial plan year.

_____ _____

AUTHORIZED SIGNATURE DATE

NORTHROP GRUMMAN FEDERAL CREDIT UNION

Membership Signature Card/Account Application/Agreement

Complete application, and securely return with a copy of your and (if applicable) the joint account holder's unexpired driver's license or state identification card along with your initial deposit. Members must open a Savings account.

PLEASE INDICATE HOW YOU ARE ELIGIBLE FOR MEMBERSHIP:

☐ Employer: _____ Site/Sector: _____

☐ Family Member - NGFCU Member Name & Membership: _____

☐ Member of Southern California Historical Aviation Foundation

REQUEST TYPE: ☐ New Member ☐ New Account

ACCOUNT TYPE: ☐ Individual ☐ Joint

☐ Savings ☐ Holiday

☐ Checking ☐ Term: _____

☐ Money Market ☐ Other: _____

ADDITIONAL SERVICES:

☐ VISA Debit Card* ☐ ATM Card ☐ Online Banking

*Checking Account required for Debit Card

SELECT YOUR DEBIT CARD:

Card Design: _____

B-2 Spirit Approach

E-2D Aerial Refueling

Riding Local

Love LA Skyline

For more card design options visit **ngfcu.us/debit-cards**

MEMBER

FULL NAME: (FIRST, MIDDLE, LAST, SUFFIX):	SOCIAL SECURITY/TIN:		
PHYSICAL ADDRESS:	CITY:	ST:	ZIP:
MAILING ADDRESS: IF DIFFERENT	CITY:	ST:	ZIP:
PHONE: ☐ CELL ☐ HOME	WORK PHONE:		
DATE OF BIRTH:	EMAIL:	GENDER ☐ M ☐ F ☐ DO NOT DISCLOSE	
DRIVER'S LIC. OR ID NUMBER:	ISSUE DATE:	EXP DATE:	STATE:
EMPLOYER:	OCCUPATION:		
CHOOSE A VERBAL CALL CENTER VERIFICATION PASSWORD: (PLEASE REMEMBER WHEN CALLING NGFCU)			

JOINT ACCOUNT HOLDER (1)

FULL NAME: (FIRST, MIDDLE, LAST, SUFFIX)	SOCIAL SECURITY/TIN:		
PHYSICAL ADDRESS:	CITY:	ST:	ZIP:
MAILING ADDRESS: IF DIFFERENT	CITY:	ST:	ZIP:
PHONE: ☐ CELL ☐ HOME	WORK PHONE:		
DATE OF BIRTH:	EMAIL:	GENDER ☐ M ☐ F ☐ DO NOT DISCLOSE	
DRIVER'S LIC. OR ID NUMBER:	ISSUE DATE:	EXP DATE:	STATE:
EMPLOYER:	OCCUPATION:		
CHOOSE A VERBAL CALL CENTER VERIFICATION PASSWORD: (PLEASE REMEMBER WHEN CALLING NGFCU)			

JOINT ACCOUNT HOLDER (2)

FULL NAME: (FIRST, MIDDLE, LAST, SUFFIX)	SOCIAL SECURITY/TIN:		
PHYSICAL ADDRESS:	CITY:	ST:	ZIP:
MAILING ADDRESS: IF DIFFERENT	CITY:	ST:	ZIP:
PHONE: ☐ CELL ☐ HOME	WORK PHONE:		
DATE OF BIRTH:	EMAIL:	GENDER ☐ M ☐ F ☐ DO NOT DISCLOSE	
DRIVER'S LIC. OR ID NUMBER:	ISSUE DATE:	EXP DATE:	STATE:
EMPLOYER:	OCCUPATION:		
CHOOSE A VERBAL CALL CENTER VERIFICATION PASSWORD: (PLEASE REMEMBER WHEN CALLING NGFCU)			

BENEFICIARY INFORMATION

BENEFICIARY 1 NAME: (FIRST, MIDDLE, LAST, SUFFIX)	SOCIAL SECURITY/TIN:	DATE OF BIRTH:	
PHYSICAL ADDRESS:	CITY:	ST:	ZIP:
BENEFICIARY DESIGNATION %:	RELATIONSHIP TO BENEFICIARY:	PHONE:	
BENEFICIARY 2 NAME: (FIRST, MIDDLE, LAST, SUFFIX)	SOCIAL SECURITY:	DATE OF BIRTH:	
PHYSICAL ADDRESS:	CITY:	ST:	ZIP:
BENEFICIARY DESIGNATION %:	RELATIONSHIP TO BENEFICIARY:	PHONE:	

☐ Additional beneficiaries are listed on the attached page, which is incorporated by reference.

The applicant hereby applies for membership in Northrop Grumman Federal Credit Union, to subscribe for at least one share and submit documentation herein. The personal information noted below is being requested and maintained in compliance with the provision of Section 326 of the USA PATRIOT Act.

TERMS AND CONDITIONS: On establishment of membership, Northrop Grumman Federal Credit Union will provide me with its Truth-in-Savings Disclosure and Agreement for various accounts and services offered by Northrop Grumman Federal Credit Union and agree to be bound by the disclosures and agreements contained therein. Further, I/we agree to be bound by the by-laws, regulations, policies and other practices of the Credit Union now in effect or as amended or later adopted regarding this account. The information stated herein is furnished to induce Northrop Grumman Federal Credit Union to open a Regular Share Account and future share accounts. I/we certify that all the information is true and correct. I/we authorize Northrop Grumman Federal Credit Union to obtain consumer reports on me and furnish information concerning my/our account to credit reporting agencies.

I authorize the Credit Union to share my name, address, e-mail address and phone number with any third party utilized to qualify me for membership.

If not applying at an NGFCU branch, please initial the following:

_____ I agree to receive the account opening disclosures and documents by email at the email address provided on this application.

SIGNATURE AND W-9 TAXPAYER ID CERTIFICATION

(Applies to both the minor and custodian)

Check appropriate boxes:

☐ I am not subject to backup withholding due to failure to report interest or dividend income

☐ I am subject to backup withholding

☐ I am exempt from FATCA reporting

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

X _____ _____

MEMBER SIGNATURE DATE

X _____ _____

JOINT ACCOUNT HOLDER 1 SIGNATURE DATE

X _____ _____

JOINT ACCOUNT HOLDER 2 SIGNATURE DATE

OFFICE USE ONLY ☐ CURRENT ID VERIFIED

MEMBER NUMBER:_____ ACCOUNT NUMBER(S):_____

EMPLOYEE NAME:_____ DATE RECEIVED:_____

CHECKBOOK/DESIGN: _____ DEBIT CARD DESIGN:_____