



DENTAL SERVICE CENTER

Dental and Vision Care Plans

Post Office Box 3907 • Gardena, CA 90247-7599

Phone: 888.293.4903 • Fax: 310.323.7012

Dental & Vision Care Plans
Offered by:



Welcome to the 2023-2024 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 **open enrollment period**. Submit your coverage by **June 15, 2023**, for your coverage to take effect on **July 1, 2023**. If you have questions, call us at **1-888-293-4903**.

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 www.cigna.com or call for live customer service - 24/7 - at **1-800-CIGNA24** (1-800-244-6224) 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 www.cigna.com or call for live customer service - 24/7 - at **1-800-CIGNA24** (1-800-244-6224) 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 www.vsp.com or call 1-800-877-7195 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 15, 2023 for coverage to begin on July 1, 2023.** 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.** Please see the rate sheet for details.*

Questions? Call us toll-free at **1.888.293.4903**.

To your good health,

The Dental Service Center Team



IMPORTANT INFORMATION ABOUT SELECTING A CIGNA DENTAL PLAN



Compare Plan features & Monthly Premiums!*

Cigna Dental Care (HMO) New

Patient Charge Schedule **P510X**

Minimize out-of-pocket expenses!

- Finding a **Dental Care network** dentist is easy:
Call a representative at 1-800-CIGNA24
(1-800-244-6224) or use the dental office locator
at www.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 1-800- CIGNA24
(1-800-244-6224) or use the dental office locator
at www.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



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.



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.

GET YOUR PERFECT PAIR

EXTRA \$20 + UP TO 40%
TO SPEND ON
FEATURED FRAME BRANDS*
SAVINGS ON LENS
ENHANCEMENTS

bebe CALVIN KLEIN COLE HAAN FLEXON
LACOSTE   NINE WEST
BY HUGO BOSS

SEE MORE BRANDS AT [VSP.COM/OFFERS](https://vsp.com/offers).



ENROLL TODAY.


Contact us: 800.877.7195 or vsp.com


- 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, 2024.

Send your completed enrollment form(s) and separate check(s) by June 15, 2023.

CIGNA Dental HMO P510X 	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.



Dental Plan Application

SELECT THE PLAN THAT'S RIGHT FOR YOU

PLEASE PRINT

1. ☐ CIGNA DPPO ☐ CIGNA DHMO
Advantage Network

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

2. I am enrolling: ☐ Myself only ☐ Myself + One ☐ Myself + Family

LIST ONLY THE MEMBERS WHO ARE TO BE INSURED BELOW

NAME: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
ADDRESS:			
CITY		STATE	ZIP
PHONE:	EMAIL:	DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

SPOUSE: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

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

CHILD: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
CHILD: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
CHILD: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

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** — Enclosed is my check to cover the first quarter's premium for the option I selected above.
I authorize Dental Service Center to deduct subsequent quarterly payments from my checking account referenced on the enclosed check. I have read and agree to the Authorization Agreement enclosed in this kit. **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.)**

Authorized Signature for Automatic Deductions

Date

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

DENTAL SERVICE CENTER
P. O. Box 3907, Gardena CA 90247-7599
Telephone 888.293.4903



Vision Care Plan Application

SELECT THE PLAN THAT'S RIGHT FOR YOU

PLEASE PRINT

1. I am enrolling: ☐ Myself only ☐ Myself + One ☐ Myself + Family

LIST ONLY THE MEMBERS WHO ARE TO BE INSURED BELOW

NAME: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
ADDRESS:			
CITY		STATE	ZIP
PHONE:	EMAIL:	DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

SPOUSE: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

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

CHILD: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
CHILD: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
CHILD: LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.:
DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

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

Authorized Signature for Automatic Deductions

Date

3. I accept the coverage/insurance benefits provided by this group vision plan and authorize the processing of my enrollment in the vision plan. I authorize any participating vision office to release vision records and billing information to VSP 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

DENTAL SERVICE CENTER
P. O. Box 3907, Gardena CA 90247-7599
Telephone 888.293.4903



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 & Relationship: _____
- ☐ Member of Southern California Historical Aviation Foundation

REQUEST TYPE: ☐ New Member ☐ New Account

ACCOUNT TYPE: ☐ Individual ☐ Joint

☐ Savings ☐ Checking ☐ Money Market ☐ Holiday Term: _____ Other: _____

ADDITIONAL SERVICES: ☐ VISA Debit Card* ☐ ATM Card ☐ Online Banking

**Checking Account required for Debit Card*

MEMBER			
FULL NAME (FIRST, MIDDLE, LAST, SUFFIX)		SOCIAL SECURITY/TIN	
PHYSICAL ADDRESS	CITY	ST	ZIP
MAILING ADDRESS IF DIFFERENT	CITY	ST	ZIP
PHONE <input type="checkbox"/> CELL <input type="checkbox"/> HOME	WORK PHONE		
CHOOSE A VERBAL PASSWORD FOR SECURITY AND ACCOUNT VERIFICATION			
DRIVER'S LIC. OR ID NUMBER	ISSUE DATE	EXP DATE	STATE
EMPLOYER	OCCUPATION		
EMAIL	BIRTHDATE MM/DD/YYYY	GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> DO NOT DISCLOSE	

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 <input type="checkbox"/> CELL <input type="checkbox"/> HOME	WORK PHONE		
CHOOSE A VERBAL PASSWORD FOR SECURITY AND ACCOUNT VERIFICATION			
DRIVER'S LIC. OR ID NUMBER	ISSUE DATE	EXP DATE	STATE
EMPLOYER	OCCUPATION		
EMAIL	BIRTHDATE MM/DD/YYYY	GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> DO NOT DISCLOSE	

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 <input type="checkbox"/> CELL <input type="checkbox"/> HOME	WORK PHONE		
CHOOSE A VERBAL PASSWORD FOR SECURITY AND ACCOUNT VERIFICATION			
DRIVER'S LIC. OR ID NUMBER	ISSUE DATE	EXP DATE	STATE
EMPLOYER	OCCUPATION		
EMAIL	BIRTHDATE MM/DD/YYYY	GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> DO NOT DISCLOSE	

BENEFICIARY INFORMATION

BENEFICIARY NAME (FIRST, MIDDLE, LAST, SUFFIX)		SOCIAL SECURITY		BIRTHDATE	
PHYSICAL ADDRESS		CITY		ST	ZIP
BENEFICIARY DESIGNATION %	RELATIONSHIP TO BENEFICIARY			PHONE	
BENEFICIARY NAME (FIRST, MIDDLE, LAST, SUFFIX)		SOCIAL SECURITY		BIRTH DATE	
PHYSICAL ADDRESS		CITY		ST	ZIP
BENEFICIARY DESIGNATION %	RELATIONSHIP TO BENEFICIARY			PHONE	

☐ Additional and/or contingent beneficiary. Use beneficiary designation form.

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 of 2001.

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.
Initial Here

SIGNATURE AND W-9 TAXPAYER ID CERTIFICATION

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 _____
DATE

OFFICE USE ONLY

MEMBER NUMBER: _____	ACCOUNT NUMBER(S): _____
EMPLOYEE NAME: _____	DATE RECEIVED: _____
CHECKBOOK / DESIGN: _____	DEBIT CARD DESIGN: _____