OPTIONAL DENTAL AND VISION BENEFITS ENROLLMENT FORM

Coalition of Public Safety Employees Health Trust

Print or Type

Return This Enrollment Form in the Enclosed Envelope by February 21, 2014

Part I.

Last Name	First Name	M.I.	Date of Birth MM/DD/YY	Sex	Social Security Number
Street Address		**Apt No.**			
City	**State**	**Zip Code**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Area Code and Telephone Number	**Email Address**				

Part II. Coverage Selection: Place an "X" in the box to indicate the plan and coverage type for your dental and/or vision selection.

Dental Coverage (Select One Dental Plan Only)	One Person	Two Persons	Family
Delta Dental PPO **Plan A** - Without Orthodontic Services - Braces	☐	☐	☐
Delta Dental PPO **Plan B** - With Orthodontic Services - Braces	☐	☐	☐

Vision Coverage	One Person	Two Persons	Family
COPS Trust Vision Plan 24	☐	☐	☐

Part III. Dependent Information: Provide the requested information for each dependent that is to be enrolled in the above selected optional dental and/or vision plans. Be sure to fill in the circle under the column "Dependent Coverage Selection" to indicate which plan(s) the dependent is to be enrolled in.

Relationship to Retiree	Dependent's Name: Last Name	First Name	M.I.	Date of Birth MM/DD/YY	Sex	Social Security Number	Dependent Coverage Selection: Dental	Vision
Spouse							◌	◌
Child							◌	◌
Child							◌	◌
Child							◌	◌

Part IV. Authorization: I have elected to enroll myself and my dependents in the above optional dental and/or vision plans. I understand that the optional dental and vision plans are NOT sponsored by the City of Detroit. This plan is not affiliated with group coverage offered by the City. I understand that the City of Detroit will not contribute to the costs of the plans. Accordingly, I understand and agree that I am solely responsible for all costs and expenses associated with the plans. I hereby authorize the Police and Fire Retirement System of the City of Detroit ("DPFRS") to deduct or recover the cost of the above selected optional dental and/or vision plans(s) from my monthly retirement pension check.

Retiree Signature _____ *Date:* _____

Return this enrollment form in the self-addressed envelope provided and mail to:

COPS Trust c/o BeneSys, Inc. • 700 Tower Drive, Suite 300 • Troy, MI 48098-2808 • Phone 248-641-4991