Charlotte Firefighters Relief and Benefit Fund

Dental and Vision

Enrollment/Change Form

Upon completion, please mail this form to:
Charlotte Fire Department
Emily Lineberger
500 Dalton Ave.
Charlotte, NC 28206

_____ First Name Middle Initial Last Name	Type of Enrollment or Change: Add/Remove Dependents: Date of Occurrence ☐ Marriage _____ ☐ Retirement _____ ☐ Divorce _____ ☐ Open Enrollment _____
Address	Phone Number / Date of Birth / Married ☐ Yes ☐ No
City, State Zip	Social Security #
Retire Date: (Employer Use)	Benefits Effective Date (1st of the month following retirement):

Member Information

Please list all eligible dependents that you want cover, and check the coverage boxes that apply. Attach additional pieces of paper if necessary.

Print Name	Gender	Date of Birth	Relationship	Dental	Vision
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Dental and Vision – Provided thru Cigna

+ SPOUSE	+ CHILD(REN)	+ SPOUSE AND CHILD(REN)
☐ $60.50/Month	☐ $71.17/Month	☐ $143.00/Month

Authorization and Signature

- I hereby authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above, if allowable, on an after tax basis. This also authorizes my employer to make this payment on my behalf in lieu of my receiving a taxable cash benefit equal to this amount.

RETIREE SIGNATURE	DATE

☐ I currently have Spouse, Children or Spouse and Children coverage and I wish to decline the coverage.