

COUNTY OF SONOMA EMPLOYEE SCPA AND SCDPDAA EMPLOYEES DENTAL PLAN ENROLLMENT/CHANGE FORM

<input checked="" type="checkbox"/> I AM ELECTING DELTA DENTAL PREMIER #3126-0224.					
ENROLLEE/CHANGE INFORMATION					
<input type="checkbox"/> New Enrollment		<input type="checkbox"/> Marital Status Change		<input type="checkbox"/> Terminate Enrollee Coverage	
<input type="checkbox"/> Add/Delete Dependent		<input type="checkbox"/> Address Change		<input checked="" type="checkbox"/> Change in Status - Adoption of Successor MOU April 19, 2016	
EMPLOYEE INFORMATION				Dental Effective Date (Office Use Only):	
Last Name		First Name		Middle Name	Employee ID
Social Security Number	Date of Birth	Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Bargaining Unit
Residential Address (Required)		<input type="checkbox"/> Check Box if new address		City	State
Mailing Address		<input type="checkbox"/> Check Box if Same as Residential		City	State
Personal Email Address		Work Phone	Personal Phone	Other Phone	
Name of Other Dental Carrier		Policy Holder Name (First/Last)			Date of Birth
Effective Date of Other Policy	Policy Holder Street Address		City	State	Zip Code

ELIGIBLE DEPENDENT INFORMATION:							
<ul style="list-style-type: none"> If you are enrolling in this dental plan for the first time or changing plans, list ALL person(s) to be covered If you are adding or deleting dependent(s) and are not new to the plan, list only the dependents you are making enrollment changes 							
Last Name, First Name, MI	Action	Check One	Date of Birth	Social Security Number	Relationship	Permanently Disabled	IRS Qualified Dependent
Spouse/Domestic Partner:							
	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children:							
	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby elect the dental plan designated on page one of this form. I have also listed my eligible dependent(s) to be added to, or deleted from, the designated dental plan. I also declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements and all eligible dependents listed as IRS Qualified dependents meet the IRC Section 152 definition of a qualified dependent.

I authorize my employer to deduct from my salary the amount required to cover my share of the premium payment (including any future premium increases). I agree for myself and my dependent(s), effective immediately and for as long as necessary to process claims:

- To be bound by the terms and conditions of the applicable Group Agreement as it may be amended
- To authorize my dentists, dental care practitioners, hospitals, clinics, or other dental or dental-related facilities to furnish any and all records pertaining to dental history, services rendered, or treatment given for purpose of review, investigation or evaluation of an application or a claim.
- To authorize a hospital or dental care plan, employer self-insurer or insurer any such dental information obtained if such disclosure is necessary to allow the processing of any claims or for purposes of utilization review or financial audit. This authorization shall become effective immediately and shall remain in effect as long as it is necessary to enable claims processing.

I understand that I must complete a new **County of Sonoma Dental Plan Enrollment/Change Form within 31 days** of a change in this qualification or a change of benefit eligibility. I understand that the employee portion of the benefit premiums will be pre-tax only for IRS Qualified dependents. Further, I understand that I am responsible for the tax consequences (including interest and penalties) should there be any misstatement made on this declaration, or even in the absence of a misstatement, should the IRS or the State of California so determine that the benefits I am receiving for dependents listed as Qualified are found to be Non-Qualified.

I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge.

Employee Signature

Date

FOR COUNTY USE ONLY:

☐ June 1, 2016 ☐ Mid-year Start Effective Date _____ Pay Date Processed _____

Eligibility Start Date _____ Premium Start Date _____ Date Entered in eP _____ Initials _____