FOR ADMINISTRATIVE USE ONLY			
Effective Date	Month	Day	Year
Event Date			
Reason			
Group Number			

Human Resources
www.sbcounty.gov/hr

COBRA Dental Plan Enrollment/Change Form

Must print in Black or Blue ink ONLY

A ☐ NEW COBRA ENROLLMENT ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS ☐ CANCEL COVERAGE

B **I ELECT THIS DENTAL PLAN** ☐ Cigna Dental DPPO ☐ Cigna Dental Care DHMO

C **MAIN SUBCRIBER INFORMATION**

Employee ID	Last Name, First Name, MI	Social Security Number	Check One ☐ Male ☐ Female	Date of Birth

Mailing Address Check here if new address ☐	City	State	Zip Code	Telephone Home ( ) Work ( )

Check One	Cigna Dental Care DHMO members must provide the following:
☐ Married/Domestic Partnership ☐ Single ☐ Divorced/Dissolution of Domestic Partnership ☐ Widowed	Dentist Name
	Provider No.

D **ENROLLMENT** **LIST ALL PERSON(S) TO BE COVERED. INCLUDE YOURSELF. PROVIDE APPROPRIATE DOCUMENTATION FOR EACH DEPENDENT IF ENROLLING FOR THE FIRST TIME.**

Action	Last Name	First Name	Social Security #	Date of Birth	Relationship
☐ Add ☐ Remove	Subscriber:				Self
☐ Add ☐ Remove	Spouse/Domestic Partner:				
☐ Add ☐ Remove	Children:				
☐ Add ☐ Remove					
☐ Add ☐ Remove					
☐ Add ☐ Remove					
☐ Add ☐ Remove					
☐ Add ☐ Remove					

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next annual COBRA Open Enrollment.

E **OTHER DENTAL COVERAGE** Are you or any member of your family covered by other group dental insurance? ☐ No ☐ Yes–Complete the following:

Enrollee's Name	Date of Birth	Insurance Company	Policy No.
Subscriber:			
Spouse/Domestic Partner:			
Children:			

F I hereby authorize my dentist, dental care practitioner, hospital, clinic, or other dental or dental-related facility 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. I also 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 certify that I have read and understand the COBRA Rights and Obligations enclosed in my COBRA election notice. I hereby elect to enroll in (or elect an authorized change to) the group dental plan maintained by the County of San Bernardino designated in Section B. I have also designated in Section D myself and/or my eligible dependents that are to be enrolled in the plan. I agree to be responsible for the full applicable premium payment for the coverage selected, which will include a 2% administration charge. I understand that failure to pay premiums timely will result in termination of coverage and that myself and my dependents' COBRA rights will be forfeited. I certify that, to the best of my knowledge, all information furnished by me herein above is true and correct. I understand that I must submit a new COBRA Dental Plan Enrollment/Change Form within 60 days of any change in status. **IF APPLICABLE**: I authorize the County of San Bernardino to deduct from my salary or monthly retirement benefit payment the amount required to cover my share of the payment (including any future premium increases or decreases).

Subscriber Signature	Date

DISTRIBUTION: Original – EBSD-HR

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