



San Bernardino County  
 Employee Benefits and Services Division (EBSB)  
 157 West Fifth Street, First Floor  
 San Bernardino, CA 92415-0440  
 (909) 387-5787 Fax (909) 387-5566

## RETIREE DENTAL PLAN ENROLLMENT/CHANGE FORM

FOR OFFICE USE ONLY			
Effective Date	Month	Day	Year
Group #			
Employee ID #			

**A**  NEW RETIREE     OPEN ENROLLMENT     CHANGE IN STATUS

**B** I ELECT THIS DENTAL PLAN:     Delta Dental PPO     DeltaCare USA HMO

**C** **RETIREE INFORMATION**

1. Social Security No.	2. Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth Month    Day    Year	4. Check One: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
5. Last Name	6. First Name	7. MI	8. For Name Change, List Former Name Here
9. Mailing Address    Check Here If New Address <input type="checkbox"/>		10. Home Phone (    ) Alternate Phone (    )	
11. City	12. State	13. Zip Code	14. DeltaCare USA members must provide the following: Provider Name _____ Provider No. _____

**D** **NEW ENROLLMENT ONLY**    IF YOU ARE ENROLLING IN THIS DENTAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED

Last Name	First Name	Social Security No.	Date of Birth	Relationship
Spouse/Domestic Partner:				
<input type="checkbox"/> Husband <input type="checkbox"/> Wife				
Children:				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				

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 Open Enrollment Period.

**E** **ENROLLMENT CHANGES ONLY**    IF YOU ARE ADDING OR DELETING DEPENDENT(S) BUT NOT CHANGING PLANS, COMPLETE THIS SECTION

Name of family member(s) to be added or deleted:	Social Security No.	Date of Birth	Relationship
<input type="checkbox"/> Add Spouse/Domestic Partner: <input type="checkbox"/> Delete			<input type="checkbox"/> Husband <input type="checkbox"/> Wife
<input type="checkbox"/> Add Children: <input type="checkbox"/> Delete			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> Son <input type="checkbox"/> Daughter

**F** IF ADDING SPOUSE/DOMESTIC PARTNER, SHOW DATE OF MARRIAGE/DOMESTIC PARTNERSHIP. IF DELETING, SHOW DATE OF DIVORCE/DISSOLUTION OR DEATH    MONTH DAY YEAR     DOMESTIC PARTNERSHIP     DISSOLUTION  
 MARRIAGE     DIVORCE     DEATH

**G** **OTHER DENTAL COVERAGE**

Are you or any other member of your family covered by other group dental insurance?     Yes     No

Insurance company \_\_\_\_\_ Spouse's/Domestic Partner's employer \_\_\_\_\_

Policy no. \_\_\_\_\_ Phone number (    ) \_\_\_\_\_

**H** 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 disclosure to 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 elect to enroll in (or make the above changes to) the dental plan as shown above and authorize deduction to be made from my monthly retirement benefit payment to cover my share of the cost of enrollment as it is now or as it may be in the future.

Retiree's Signature \_\_\_\_\_

Date \_\_\_\_\_

RETURN FORM TO:

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