SAN BERNARDINO COUNTY

Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

DENTAL PLAN ENROLLMENT/CHANGE FORM

Must print in Black or Blue ink ONLY

☐ New Employee ☐ Change in Status ☐ Open Enrollment

I ELECT THIS DENTAL PLAN ☐ Delta Dental DPPO ☐ DeltaCare USA DHMO

EMPLOYEE INFORMATION

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

Mailing Address	Check box if new address☐	City	State	Zip Code	Telephone

Residential Address	Check box if new address☐	City	State	Zip Code	Date of Hire

Email Address	DeltaCare USA DHMO members must provide the following: Dentist Name and Provider No.	Previously Visited? ☐ Yes ☐ No

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 AND PROVIDE APPROPRIATE DOCUMENTATION FOR EACH

Last Name, First Name, MI	Sex	Date of Birth	Social Security Number	Relationship	DeltaCare USA DHMO Enrollees Only: Dentist Name and Provider No.		Previously Visited?
Spouse/Domestic Partner:	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
Children:	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No

ENROLLMENT CHANGES ONLY — IF YOU ARE ADDING OR DELETING DEPENDENT(S) BUT NOT CHANGING PLANS, COMPLETE THIS SECTION AND PROVIDE APPROPRIATE DOCUMENTATION FOR EACH

Last Name, First Name, MI	Sex	Date of Birth	Social Security Number	Relationship	DeltaCare USA DHMO Enrollees Only: Dentist Name and Provider No.		Previously Visited?
Spouse/Domestic Partner: ☐Add ☐Delete	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
Children: ☐Add ☐Delete	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
☐Add ☐Delete	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
☐Add ☐Delete	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
☐Add ☐Delete	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
☐Add ☐Delete	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No
☐Add ☐Delete	☐M ☐F				Dentist Name: Provider No.:		☐Yes ☐No

IF ADDING A SPOUSE/DOMESTIC PARTNER, INDICATE DATE OF MARRIAGE/DOMESTIC PARTNERSHIP. IF DELETING, INDICATE DATE OF DIVORCE/DISSOLUTION OF MARRIAGE OR DEATH.	Month	Day	Year	☐ Married/Domestic Partnership ☐ Divorce/Dissolution of Domestic Partnership ☐ Death

OTHER DENTAL COVERAGE Are you or any other member of your family covered by other group dental insurance? ☐ Yes ☐ No	Insurance Company/Policy Number:
Spouse/Domestic Partner's Employer:	Phone Number:

ENROLLED DISABLED DEPENDENTS	
List the names of any disabled dependents you are enrolling below:	
Last Name, First Name, MI	Last Name, First Name, MI
Last Name, First Name, MI	Last Name, First Name, MI
Last Name, First Name, MI	Last Name, First Name, MI

DELTA DENTAL

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.

MID YEAR CHANGE

I understand that if at any time my or my family's eligibility changes, I will notify EBSD-HR or department payroll specialist within **60** days of the change in order to make the appropriate changes to my benefit deductions. *For example, if I get divorced I am required to remove my ex-spouse from County sponsored Benefit Plans.*

I elect to enroll in (or change to) the dental plan as shown above and authorize deductions to be made from my salary to cover my share of the cost of enrollment as it now or as it may be in the future. I agree to accept the terms to which I subscribe.

DEPENDENT AFFIDAVIT

I understand and agree to each of the following:

- My enrolled dependent(s) meet the definition of an "eligible dependent" as defined in the Employee Benefits Guide, applicable Memoranda of Understanding, and plan eligibility requirements by carrier. A complete list of dependent eligibility criteria may be found on the Human Resources Department - Employee Benefits and Services Division (HR-EBSD) internet and intranet sites.
- If I falsify dependent eligibility information to enroll an ineligible dependent, my dependent's coverage will be terminated in accordance with the provisions of the benefit plan contract. Any inconsistencies discovered with respect to enrollment and eligibility will be investigated and I may be subject to disciplinary action up to and including termination of employment.
- The County reserves the right to request adequate documentation to asses a dependent's eligibility. Failure to submit requested information may result in immediate termination of the dependent's coverage from the County's group plans.
- It is my responsibility to:
  - Notify HR-EBSD within 60 days of the family status change date that would make one or more of my dependents ineligible for group health coverage
  - Provide supporting documentation upon request of HR-EBSD
- I am responsible for any applicable cost incurred for obtaining supporting documentation.
- The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively.
- If it is found that I am covering or have covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf. Additionally, I will reimburse the County for any portion of the employer contribution paid to the carrier(s) for the period of time coverage was provided for my ineligible dependent.
- Failure to notify HR-EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for coverage for which your dependent was ineligible. Any refunds owed for such premiums are a the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County dopes not assure any liability resulting from terminating coverage of ineligible dependent(s).

By signing below, I certify and affirm to San Bernardino County that the dependent(s) eligibility information submitted is true, correct , and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, term of benefit plan contracts, County policies, applicable Memoranda of Understanding, and related state and/or federal law(s).

AGREEMENT

By signing below, I certify and affirm to San Bernardino County that the dependent eligibility information submitted is true, correct, and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plans contracts, County policies, and related state and/or federal law(s).

Note: A Premium Deduction Election form must accompany this form	**Employee Signature**	**Date**

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

HR USE ONLY			
Keyed By (Employee ID)	**Date**	**Pay Period Effective**	**Effective Date**