



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 DELTA DENTAL PPO PLAN ENROLLMENT/CHANGE FORM

Effective Date	Month	Day	Year
Group #			
Employee ID #			

A NEW RETIREE OPEN ENROLLMENT CHANGE IN STATUS

B Previous Dental Plan: _____

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 () Work Phone ()	
11. City	12. State	13. Zip Code	

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 retiree pay warrant 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:

San Bernardino County
Employee Benefits and Services Division (EBSD)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440