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COUNTY OF SONOMA EMPLOYEE
SCLEA, SCLEMA AND SCPDIA EMPLOYEES
DENTAL PLAN ENROLLMENT/CHANGE FORM

☒ **I AM ELECTING DELTA DENTAL PREMIER #3126-0224.**

ENROLLEE/CHANGE INFORMATION

☐ New Enrollment	☐ Marital Status Change	☐ Terminate Enrollee Coverage
☐ Add/Delete Dependent	☐ Address Change	☒ Change in Status - Adoption of Successor MOU May 24, 2016

EMPLOYEE INFORMATION

Office Use Only:	Dental Effective Date	HR Technician Initials	Date Entered into eP

Last Name	First Name	Middle Name	FTE	Employee ID

Social Security Number	Date of Birth	Check One	Marital Status	Bargaining Unit
		☐ Male ☐ Female	☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Widowed	

Residential Address (Required) ☐ Check Box if new address	City	State	Zip Code

Mailing Address ☐ Check Box if Same as Residential	City	State	Zip Code

Personal Email Address	Work Phone	Personal Phone	Other Phone

Check One:
☐ Employee Only
☐ Employee + 1
☐ Employee + 2 or more

ELIGIBLE DEPENDENT INFORMATION: List ALL person(s) to be covered

Last Name, First Name, MI	Action	Check One	Date of Birth	Social Security Number	Relationship	Permanently Disabled	IRS Qualified Dependent
Spouse/Domestic Partner:							
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
Children:							
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ No
	☐Add ☐Delete ☐Waive	☐ Male ☐ Female				☐ Yes ☐ No	☐ Yes ☐ 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