CSU The California State University

DENTAL PLAN ENROLLMENT AUTHORIZATION

D

CSU692R (REV. 03-2013)

PLEASE FORWARD COMPUTER-GENERATED FORM OR PRINT CLEARLY USING BALL POINT PEN – SEND COMPLETED FORM TO CALPERS, HEALTH ACCOUNT SERVICES, P.O. BOX 942714, SACRAMENTO, CA 94229-2714

SECTION A

1. TYPE OF ACTION

☐ NEW – ENROLLING IN A PLAN FOR THE FIRST TIME (COMPLETE SECTIONS A, B, AND D)

☐ CANCEL - (COMPLETE SECTIONS A, C AND D

☐ CHANGE – CHANGING PLANS OR DEPENDENT COVERAGE (COMPLETE SECTIONS A, B, C, D)

2. NAME (FIRST) (MIDDLE) (LAST)

ADDRESS (NUMBER AND STREET)

(CITY, STATE, ZIP)

3. MARITAL STATUS

___ MARRIED ___ SINGLE ___ REGISTERED DOMESTIC PARTNERSHIP (RDP)

4. GENDER

___ MALE ___ FEMALE

5. SOCIAL SECURITY NUMBER (EMPLOYEE'S SSN) ______________________

6. SPOUSE OR REGISTERED DOMESTIC PARTNER (RDP) SSN ______________________

SECTION B

1. NAME OF DENTAL PLAN

2. PROVIDER FACILITY NUMBER) (applicable to DeltaCare USA Plan only)

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL ELIGIBLE FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE "A" (ADD) AND/OR "D" (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (INCLUDING SELF)	DATE OF BIRTH MO	DAY	YR	FAMILY RELATIONSHIP	GENDER
					SELF	
	SSN					
	SSN					
	SSN					
	SSN					
	SSN					
	SSN					
	SSN					
	SSN					

SECTION C

1. PRIOR DENTAL PLAN NAME

SECTION D – EMPLOYEE AND EMPLOYER AUTHORIZATION

1. Check one below:

_____ I DO NOT WISH TO ENROLL IN A DENTAL PLAN

_____ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE PRE-TAX DEDUCTIONS TO BE MADE FROM MY RETIREMENT ALLOWANCE TO COVER MY SHARE (IF APPLICABLE) OF THE COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B; ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY CALIFORNIA STATE UNIVERSITY AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

_____ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.

1. EMPLOYEE'S OR ANNUITANT'S SIGNATURE (See Privacy Information on reverse)

2. DATE SIGNED

1. CSU DEDUCTION CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD (MMYYYY)	5. CSU SHARE AMOUNT	6. EMPLOYEE SHARE	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU - 150			MONTH | YEAR	$	$			$

PRIOR DENTAL PLAN INFORMATION			12. PERMITTING EVENT DATE	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION	15. AGENCY CODE	16. UNIT CODE	17. RETIREMENT SYSTEM
10. PRIOR CSU DEDUCTION CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE						

18. **REMARKS**

19. **AUTHORIZED CAMPUS BENEFITS OFFICE SIGNER (PLEASE PRINT)**

20. TELEPHONE NUMBER

21. **AUTHORIZED CAMPUS BENEFITS OFFICE SIGNATURE**

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting Benefits officer or authorized campus designee and that I am authorized to make this certification; that the employee (and any named dependents) named herein is eligible for enrollment in the CSU Dental Program.

22. **EMAIL ADDRESS**

23. DATE RECEIVED IN CAMPUS BENEFITS OFFICE (M/D/Y)

DISTRIBUTION: ORIGINAL – CalPERS COPY – Campus File COPY - Employee (with privacy notice)

PRIVACY NOTICE

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and state benefits. Furthermore, the Office of Employer and Member Health Services requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

Specifically, the California Public Employees' Retirement System uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Payroll deduction and state contribution for state employees/annuitants.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to the Public Employees' Retirement System and other state agencies.
5. Coordination of benefits among carriers.

Information provided on the form will be forwarded to the dental insurance company providing coverage for the annuitant.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, PERS, P.O. Box 942714, Sacramento, CA 94229-2714.