

DENTAL PLAN ENROLLMENT/CHANGE REQUEST

PLEASE COMPLETE AND RETURN THIS FORM TO:

CalPERS Health Account Services
 P.O. Box 942714
 Sacramento, CA 94229-2714
 888 CalPERS or (888) 225-7377
 TTY (877) 249-7442
 Fax (916) 795-1277



IF YOU HAVE NO COVERAGE CHANGES -- DO NOT RETURN THIS FORM

MEMBER'S SOCIAL SECURITY NUMBER -- --	SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER -- --
NAME IN FULL (First) (Middle) (Last)	
YOUR MAILING ADDRESS (NUMBER & STREET) _____ (CITY) _____ (STATE & ZIP CODE) _____	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARRIED <input type="checkbox"/> Yes <input type="checkbox"/> No
DOMESTIC PARTNERSHIP <input type="checkbox"/> Yes <input type="checkbox"/> No	
Your Birth date: ___/___/___	
DAYTIME TELEPHONE NUMBER: ()	
NAME OF DENTAL PLAN: _____ (For enrollments or plan changes)	
NAME OF <u>PRIOR</u> STATE DENTAL PLAN: _____ (For plan changes only)	
IF CHOOSING A PRE-PAID PLAN ENTER THE NAME OF THE FACILITY NUMBER: _____.	
<u>NAME OF ELIGIBLE DEPENDENTS</u>	<u>BIRTH DATE</u>
<u>RELATIONSHIP</u>	
_____	_____
_____	_____
_____	_____
Event for Add/Change: <u>OPEN ENROLLMENT</u> Event Date: <u>September 10 through October 5, 2012</u>	
NOTE: To enroll a spouse, you must attach a copy of your marriage certificate and provide your spouse's Social Security Number. To enroll a Domestic Partner, you must attach a copy of the Secretary of State's required filing documents and provide your partner's Social Security Number. Dependents, including dependents of domestic partners must be listed (name, birth date and relationship to retiree)	
1. <input type="checkbox"/> PLEASE CANCEL MY COVERAGE ON A PROSPECTIVE BASIS. I DO NOT WISH TO BE ENROLLED IN A DENTAL PLAN OFFERED TO ME AS A STATE RETIREE. (Check box)	
2. <input type="checkbox"/> I ELECT TO <u>ENROLL/CHANGE</u> TO THE DENTAL PLAN INDICATED ABOVE, AND/OR <u>ADD/DELETE</u> ELIGIBLE FAMILY MEMBERS. I ALSO AUTHORIZE DEDUCTIONS, IF APPLICABLE, TO BE MADE FROM MY RETIREMENT ALLOWANCE TO COVER MY SHARE OF THE COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. (Check box and Circle election)	
3. SIGNATURE:	DATE FORM SIGNED: Month : Day : Year : : : :

The Information Practice Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the California Department of Human Resources and the dental insurance company for the purpose of identification and dental coverage processing.

It is **mandatory** to furnish all information requested on this form. Failure to provide the **mandatory** information may result in the dental enrollment action not being processed or being processed incorrectly.

The California Department of Human Resources requires social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151, 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the dental company providing coverage. Copies of the RETIREE DENTAL PLAN ENROLLMENT/CHANGE REQUEST form are maintained in confidential files of the California Public Employees' Retirement System (CalPERS) for five years. Individuals have the right of access to copies of their RETIREE DENTAL PLAN ENROLLMENT/CHANGE REQUEST form upon request. Send requests to: California Public Employees' Retirement System (CalPERS), P. O. BOX 942714, SACRAMENTO, CA 94229-2714, Attn: Health Benefit Service Division.