State of California

M E M O R A N D U M

To: PERSONNEL MANAGEMENT LIAISONS

Date: January 14, 1991
Reference Code: 91-04

THIS MEMORANDUM SHOULD BE DISTRIBUTED TO:

ALL PERSONNEL OFFICERS AND PERSONNEL TRANSACTION STAFF

From: **Department of Personnel Administration**

Subject: Dental Benefits for Exempt Employees Separating from State Service

Existing law allows certain exempt employees who meet applicable eligibility requirements, and who are separating and pending retirement from State service, to continue their health and dental benefits by paying direct to the carrier. The current rate is 102% of the current State rate. While this rate is the same as the COBRA rate, continuation of coverage in these instances is not part of the COBRA. For the details of the law and specific eligibility requirements, please refer to the PERS Memorandum of December 24, 1990 which addresses the subject of SB 2026.

Enrollment Document - Delta Dental

Eligible exempt employees covered by Delta Dental who wish to pay direct should complete a "Delta 602" form. A completed sample of this form is attached for your reference. The following statement should be written in red at the top of each form: "Based on Section 22816.7 of the Government Code." These forms can be obtained from Delta Dental's Marketing Administration by calling (415) 972-8300. The enrollment document and the initial payment should be sent to PERS for verification of eligibility. PERS will forward the enrollment document and payment to Delta for processing.

Direct Pay Premium - Delta Dental

To continue dental benefits with Delta Dental, eligible exempt employees must make their direct premium payments on a quarterly schedule. After the initial enrollment, employees will be required to submit payments directly to Delta on or before the first day of the month that the quarter begins (January, April, July and October). Non-payment for two consecutive quarters will automatically disqualify the employee from this program.

The direct pay premiums for Delta Dental are as follows:

	Monthly Rate	Quarterly Premium Amount Due
One Party (one person enrolled)	$25.46	**$ 76.38**
Two Party (two people enrolled)	$52.53	**$157.59**
Three Party (three or more people enrolled)	$74.12	**$222.36**

To ensure that the quarterly premiums are credited properly, the employees should write their social security number and group number 9949-8601 on their payment checks.

RTD/055

Direct Pay for Prepaid Plans

Eligible exempt employees covered by a prepaid dental plan (CDHP, DentiCare or PMI) who wish to continue coverage through direct pay, should complete a Dental Plan Direct Payment Authorization Form (Std. 696). The following statement should be written in red at the top of each form, "Based on Section 22816.7 of the Government Code". The Std. 696 and the initial premium payment should be sent to the attention of Janice Yates, Statewide Dental Coordinator, Department of Personnel Administration, 1515 "S" Street, North Building, Suite 400, Sacramento, CA 95814-7243 (IMS Code is D-22). Subsequent direct payments should be made directly to the carrier.

The direct pay premiums for the prepaid plans will be done on a monthly basis as follows:

	One Party	Two Party	Family (3 or more)
CDHP	$ 9.76	$15.61	$20.99
DentiCare	$ 9.28	$15.25	$21.37
PMI	$10.17	$16.68	$23.07

If you have any questions regarding the information in this memo, please contact Janice Yates at (916) 324-0535 or ATSS 454-0535.

Patricia Pavone, Chief
Benefits Division

Attachment

RTD/055

DELTA/PMI

Based on Section 22816.7 of the Government Code.

SAMPLE

Enrollment Application — Please print or type — press firmly

A ENROLLEE

Program(s) you are enrolling in: ☒ DELTA DENTAL ☐ DELTA Care (PMI) ☐ DELTA Vision (PMI) ☐ COBRA

Name: First	Middle initial	Last	Social security number
John	T.	Doe	444 — 88 — 1616

Hire date: ___ / ___ / ___ (Month / Day / Year)

Group name: State of California

Location or branch: 9949-8601 Local no.: ___

Prior social security number under Delta: — —

Birth date: 01 / 05 / 49 (Month / Day / Year) Sex: ☒ Male ☐ Female

Marital status: ☐ Single ☐ Divorced ☒ Married ☐ Separated

Employment status: ☐ Full-time ☐ Retired ☐ Part-time ☐ Certificated ☐ Union ☐ Classified ☐ Non-union

Mailing address: 2123 First Street (Street) Telephone: (916) 333-4444

City: Sacramento State & Zip: CA 95814

Does your spouse have a dental plan? ☐ Yes ☒ No

If yes who is covered? ☐ Yourself ☐ Spouse ☐ Dependent children

Other insurance company name: ___

Do you have dependent children? ☒ Yes ☐ No

Are you enrolling your dependents? ☒ Yes—Complete section B ☐ No

For Delta/PMI use only

Delta group number: ___

PMI group number: ___

Vision group number: ___

Effective date: ___

Elig. code: ___

☐ 18 mos. ☐ 36 mos.

B DEPENDENTS

Spouse name: First	Middle initial	Last (if different)	Add/ Delete	Sex M F	Birthdate Month Day Year	Marriage date Month Day Year
Mary	S.			F	01/01/49	/ /

Child name: First	Middle initial	Last (if different)	Add/ Delete	Sex M F	Birthdate Month Day Year	If child is 19 or over (check one): Full-time Student	Disabled
1. David	R.			M	03/11/75		
2.					/ /		
3.					/ /		
4.					/ /		
5.					/ /		
6.					/ /		
7.					/ /		

E Changes

ENROLLEE

☐ Name change

List new name in section A

Former name: ___

DEPENDENT

List dependents in section B

Reason(s) for change: ___

Effective date of change: ___ / ___ / ___ (Month / Day / Year)

C

Please indicate dental location choice ___ Location number ___

Please indicate vision location choice ___ Location number ___

Verification: I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Signature John T. Doe Date 12 / 26 / 90

D COBRA

Qualifying COBRA Event:

☐ Termination ☐ Divorced ☐ Medicare
☐ Retirement ☐ Widowed ☐ Overage dependent
☐ Reduction in hrs. ☐ Surviving dependent ☐ Legal separation
☐ Other ___

Qualifying date: ___ / ___ / ___ (Month / Day / Year)

— — Prior social security number under Delta

I understand that I may be required by the employer to pay for these benefits.

Signature John T. Doe Date 12 / 26 / 90

Delta 602 (2/89) **Delta Dental copy—white** **PMI copy—canary** **Employer copy—pink**