Contra Costa County Open Enrollment Change form for Plan Year January 1, 2014 - December 31, 2014 DENTAL PLAN

For Use with CalPERS Medical Plans

AREA 1 - PERS	SONAL INFORMATION	V						
NAME (Last)		(First)		(MI)	SOCIAL SECURITY NUM	BER	EMPLOYEE NUMBER	
ADDRESS					DATE OF BIRTH			
CITY		ZIP	DATE OF H	RE	HOME PHONE NUMBER			
WORK DEPARTMENT				WORK PHONE NUMBER			MALE	FEMALE
MARITAL STATUS	: SINGLE	MARR	IED DIV	ORCED S	SEPARATED WIDOWE	D DOMES	TIC PARTNER	
WORK STATUS:	PERMANENT PROVISIONA		PERMANI	ENT INTERMIT	TENT PERMANENT PA		HRS. PER	WEEK
AREA 2 - SELE	ECT COVERAGE							
						DENTAL		
DELTA DENTAL	EMPLOY'EE	ONLY	EMPLOYEE	AND FAMILY				1
PMI DELTACARE					Coverage Waived for Emp	oloyee and Far	mily	
AREA 3 - DEN	TAL ENROLLMENT					Group #		
For Office Use Only					Effective Date:			□No
A = ADD D = DELETE	LAST NAME, FIRST NA	ME, M.I.	DATE OF BIRTH	SEX M/F	RELATION TO YOU			PRIMARY CARE DENTIST
	1				EMPLOYEE			
	2		1		SPOUSE			
	3							
	4							
	5							
	6							
	OTE: IF ENROLLING DEPENT LEAST 50% DEPENDENT		DREN AGE 19	AND OLDER,	YOU ARE INDICATING TH	E DEPENDEN	T CHILD IS UI	NDER 24, A FULL TIME
	ER GROUP COVERAG							
	OF YOUR DEPENDENTS HA INDIVIDUAL(S) COVERED:	AVE OTHER	DENTAL INSU	IRANCE COVE	ERAGE? Yes	☐ No		EMPLOYER/ PLAN NAME:
Is your spouse/	domestic partner a curr	ent employ	ee or retiree	e of Contra	Costa County or Specia	al District?		B V
If yes, ple	ease provide their emplo	yee numb	er:					Yes No
due as my contrib	ontra Costa County Audito oution for the Plans in which it, the payment will not be r's Office by the 10th of ea	ch I have ele deducted ar	ected to partic nd that it is m	cipate. Furthe y responsibili	er I understand that if my of ty to make that payment of	check is not la directly to the	arge enough	for the full
	ifies that I have reviewed thermore, all persons liste							
EMPLOYEE/RETIREE/SURVIVING SPOUSE SIGNATURE					DATE SIGNED			

*Completed forms must be received by the Contra Costa County Human Resources Department, Employee Benefit Services Unit at 651 Pine Street, Fifth Floor, Martinez, CA 94553. Remember, Dependent Eligibility Documentation is to be included with this enrollment form.

TERMS & CONDITIONS DENTAL ENROLLMENT FORM

Your signature on the front of this form constitutes your authorization to deduct from your paycheck or pension benefit check the amount of your monthly premium, and, indicates you have read and understand the following terms, conditions and provisions:

- 1. The Employee Benefits Services Unit will enroll you and your eligible dependents in the dental plan you have elected and in which you are eligible to participate.
- 2. Application to change your dental elections after this open enrollment can only be done in accordance with the provisions of the IRC, Section 125 as it relates to qualifying status change events. The change will be effective the first day of the month coincident with or next following the date the completed and approved change form is received by the Employee Benefits Services Unit. All non qualified changes can be made during the next open enrollment period
- 3. It is against County Policy for an employee to enroll ineligible persons as dependents; to do so may subject the employee to disciplinary action as well as the obligation to reimburse the plan for all costs associated with the delivery of dental care services to an ineligible person. Please see the list of required documents needed to enroll a spouse/domestic partner and/or a dependent child, failure to provide these documents will result in no coverage.
- Coverage under the Contra Costa County Dental Benefit Plans ceases for you and your dependents on the last day of the pay period in which your employment terminates. Benefits can be extended for service related or disability related retirements in accordance with CCCERA provisions for retirement. Additionally, Federal law requires that most group health plans give employees and their eligible covered dependents the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan and the covered employee's spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children and alternative recipients under Qualified Medical Child Support Orders (QMSCOs) may also be qualified beneficiaries. In the case of loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to 18 months. In the case of loss of coverage due to an employee's death, divorce or legal separation or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA may be continued for up to 36 months. COBRA coverage will automatically terminate before the end of the maximum period if (1) a required premium is not paid-infull and on time; (2) a qualified beneficiary becomes covered, after electing COBRA coverage under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied. (3) a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing COBRA coverage; (4) The County ceases to provide any group health plans for its employees; or (5) during a disability extension period the qualified beneficiary is determined by the Social Security Administration to be no longer disabled. At the end of COBRA continuation, you may be eligible for a conversion to an individual policy, if your plan has a conversion policy provision.
- 5. The non-payment of any premiums results in termination of coverage for you and your eligible dependents. If you are unable to make a payroll or pension check deduction, all premiums must be made by check payable to and received in the Contra Cost County Auditor-Controller's office by the 10th of the month in which the payment is due.
- 6. If the plan service agreement of the dental plan you have selected contains a binding arbitration clause, you understand as part of your membership any monetary claim asserted by you or your eligible dependents, heirs or personal representative, on account of bodily injury, mental disturbance, death or any other issue, must be submitted to binding arbitration instead of a court trial. Refer to your plan booklets to determine if this provision is applicable to your plan.
- 7. You must authorize any person or hospital who has rendered dental services to you or to any dependents covered by this application to make available to the dental plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the dental plan. Such information may also be released to persons or entities which in conjunction with or at the direction of the dental plan are conducting a review of cost, quality and/or appropriateness of services rendered. You also agree to complete and submit to the dental plan any necessary forms, consents, releases, assignments, application, questionnaires and other documents that the plan may reasonably request, and that you will authorize the release of information contained on this form to the applicable plan(s) and that all information so supplied is true, correct and complete.

For assistance in selecting dentist, please call the carriers at:

- Delta Dental 1 (800) 765-6003 or www.deltadentalins.com
- Delta PMI 1 (800) 422-4234 or www.deltadentalins.com