

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY—SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

| SECTION A | | | | SECTION B | | | | | | | | | | | | | | |
|--|--|---------------------|---|--|---|-----------------------------------|--|-------------------------------------|-----------------|---|--|-------------------------|--|--------------------|---|-----------------------------------|--|--|
| 1. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME <i>(Complete Sections A, B, and D)</i> <input type="checkbox"/> CANCEL - <i>(Complete Sections A, C, D, and Personnel Office complete E Box 4, 14)</i> <input type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE <i>(Complete Sections A, B, C, and D)</i> <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE <i>(Complete Sections A, B, and D)</i> | | | | 1. NAME OF DENTAL PLAN 2. PROVIDER/FACILITY NUMBER <i>(If applicable) (prepaid plans only)</i> 3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL 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. | | | | | | | | | | | | | | |
| 2. NAME <i>(First)</i> _____ <i>(Middle)</i> _____ <i>(Last)</i> _____ ADDRESS <i>(Number and Street)</i> _____ <i>(City, State, and Zip)</i> _____ | | | | A C T I O N C O D E | LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (include self) <i>(First)</i> _____ <i>(Middle)</i> _____ <i>(Last)</i> _____ | | | DATE OF BIRTH MONTH DAY YEAR | | | FAMILY RELATIONSHIP SELF | GENDER | | | | | | |
| 3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/> | | | | 4. MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER | | | 5. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | | SSN | | | | | | | | |
| 6. SOCIAL SECURITY NUMBER | | | | 7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER | | | | | | | | | | | | | | |
| SECTION C <i>(Complete for Plan changes if different than B-1 and cancellations only)</i> | | | | 1. PRIOR DENTAL PLAN NAME | | | | | | | | | | | | | | |
| SECTION D | | | | 1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN <i>(Keep in employee's file)</i> <input type="checkbox"/> I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF 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 THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE | | | | | | | | | | | | | | |
| 2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE <i>(See Privacy Information on reverse of employee copy.)</i> | | | | | | 3. DATE SIGNED | | | | | | | | | | | | |
| SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY) | | | | | | | | | | | | | | | | | | |
| 1. EMPLOYER DED.CODE <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351 | | 2. DENTAL ORG. CODE | | 3. PARTY CODE | | 4. PAY PERIOD MONTH YEAR | | 5. STATE SHARE AMOUNT \$ | | 6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ | | 7. EMPLOYEE DESIGNATION | | 8. BARGAINING UNIT | | 9. TOTAL PREMIUM AMOUNT \$ | | |
| COMPLETE ON CHANGES ONLY | | | 12. PERMITTING EVENT DATE MONTH DAY YEAR | | 13. PERMITTING EVENT CODE | | 14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR - 1 - | | 15. AGENCY CODE | | 16. UNIT CODE | | 17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) <input type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE | | | | | |
| 10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351 | | | 11. PRIOR DENTAL ORG. CODE PRIOR PARTY CODE | | 18. REMARKS | | | | | | | | 19. SIGNING PERSONNEL OFFICER'S NAME <i>(Please Print)</i> | | | | | |
| 20. AUTHORIZED AGENCY SIGNATURE <i>I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.</i> | | | | | | | | | | | | | 21. TELEPHONE NUMBER <i>(Include Area Code)</i> | | 22. DATE RECEIVED IN EMPLOYING OFFICE MONTH DAY YEAR | | | |
| 23. EMAIL ADDRESS | | | | | | | | | | | | | 22. DATE RECEIVED IN EMPLOYING OFFICE MONTH DAY YEAR | | | | | |

PRIVACY NOTICE

The Information Practices 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 State Controller's Office and the dental insurance company for the purposes of identification and dental coverage processing.

It is **mandatory** to furnish all information requested on this form except for employee's gender and marital status, which may be furnished on a voluntary basis and are used by the dental insurance company for statistical and actuarial purposes. Failure to provide the **mandatory** information may result in the dental enrollment action not being processed or being processed incorrectly.

The State Controller's Office requires employee's 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 insurance company providing coverage for the employee. Copies of the Dental Plan Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Dental Plan Enrollment Authorization forms upon request. Send requests to: State Controller's Office, Personnel/Payroll Operations Bureau, P. O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.