SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services

Print Form

FOR ADMINISTRATIVE USE ONLY
Effective Date
Event Date
Reason
Plan No.

COBRA
DENTAL PLAN ENROLLMENT/CHANGE FORM

CHOOSE ONE: ☐ NEW COBRA ENROLLMENT ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS ☐ CANCEL COVERAGE

SELECT PLAN			
COBRA ACTIVE PLANS:	☐ DELTACARE USA DHMO	☐ DELTA DENTAL DPPO	
RETIREE PLANS: (Dependent Only)	☐ DELTACARE USA DHMO	☐ DELTA DENTAL DPPO LOW	☐ DELTA DENTAL DPPO HIGH

MAIN SUBSCRIBER INFORMATION

Check one ☐MALE ☐FEMALE Check one ☐SINGLE ☐MARRIED ☐DOMESTIC PARTNER ☐DIVORCED ☐WIDOWED

Empl. No.	Social Security No.	Last Name	First Name	MI	Date of Birth	For name change, list former name here

Mailing Address ☐ Check here if new address	City	ST	ZIP	Phone ☐HOME ☐CELL ☐WORK	Email Address

DeltaCare USA DHMO members must provide the following: Dentist Name: ____________ Provider No. ____________ Previously Visited? ☐ Y ☐ N

ENROLLEES - List ALL persons to be covered

Include yourself. You must also attach proof of dependent eligibility if enrolling dependents for the first time.

Action	Name (Last Name, First Name)	Social Security No.	Sex	Date of Birth	Relationship	DeltaCare USA DHMO Members Only: Enter Dentist Name & Provider Number	Previously Visited?
☐ Add ☐ Remove	Subscriber:		☐ M ☐ F		Self	NAME: PROVIDER NO:	☐ Y ☐ N
☐ Add ☐ Remove	Spouse/Domestic Partner:		☐ M ☐ F			NAME: PROVIDER NO:	☐ Y ☐ N
☐ Add ☐ Remove	Children:		☐ M ☐ F			NAME: PROVIDER NO:	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			NAME: PROVIDER NO:	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			NAME: PROVIDER NO:	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			NAME: PROVIDER NO:	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			NAME: PROVIDER NO:	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			NAME: PROVIDER NO:	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			NAME: PROVIDER NO:	☐ Y ☐ N

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next annual COBRA Open Enrollment, unless I experience a qualifying mid-year change-in-status event.

OTHER DENTAL COVERAGE

Are you or any other enrollee covered by other group dental insurance? ☐No ☐Yes - Please complete the following:

Enrollee's Name	Date of Birth	Insurance Company	Policy No.
Subscriber:			
Spouse/Domestic Partner:			
Children:			

CONTINUED ON NEXT PAGE

DISTRIBUTION: HR - EBSD (0440)

AGREEMENT - THIS SECTION MUST BE COMPLETED BY ALL SUBSCRIBERS

I hereby authorize my dentist, dental care practitioner, hospital, clinic, or other dental or dental-related facility to furnish any and all records pertaining to dental history, services rendered, or treatment given for purpose of review, investigation or evaluation of an application or a claim. I also authorize a hospital or dental care plan, employer self-insurer or insurer to obtain any such dental information to allow the processing of any claims or for purposes of utilization review or financial audit, if such disclosure is necessary. This authorization shall become effective immediately and shall remain in effect as long as it is necessary to enable claims processing.

I understand that if at any time my or my family's eligibility changes, I will notify EBSD-HR or department payroll specialist within 60 days of the change in order to make the appropriate changes to my benefit deductions. For example, if I get divorced I am required to remove my ex-spouse from County sponsored Benefit Plans. I elect to enroll in (or change to) the dental plan as shown above and authorize deductions to be made from my salary to cover my share of the cost of enrollment as it now or as it may be in the future. I agree to accept the terms to which I subscribe.

I certify that, to the best of my knowledge, all information furnished by me herein above is true and correct. I understand that I must submit a new COBRA Dental Plan Enrollment/Change Form within 60 days of any change in status.

I certify that I have read and understand my and/or my dependents' COBRA Rights and Obligations enclosed in my COBRA Election Notice. I hereby elect to enroll in (or elect an authorized change to) the group dental plan maintained by San Bernardino County designated at the beginning of this form. I have also designated in the ENROLLEES section myself and/or my eligible dependents who are to be enrolled into the dental plan. I agree to be responsible for the full applicable premium payment for the coverage selected, which will include a 2% administration charge. I understand that failure to pay premiums timely will result in the termination of coverage and that my and my dependents' COBRA rights will be forfeited.

I acknowledge and understand that dental care providers may disclose health information about me or my dependents for purposes of treatment, payment, health care operations, and as permitted or required by law. The DHMO dental insurance carrier's Notice of Privacy Practices can be obtained at its website or by calling member services. The DPPO Notice of Privacy Practices can be obtained at San Bernardino County's Human Resources/Employee Benefits and Services website.

If applicable: I authorize San Bernardino County to deduct from my salary or monthly retirement benefit payment the amount required to cover my share of the payment (including any future premium increases or decreases).

Subscriber's Signature _____ ***Date*** _____

For COBRA Dependent Premium Payment Authorization Only:

To authorize that your monthly COBRA payment be deducted from the monthly retirement benefit payment of your spouse, parent or state-registered domestic partner AND he or she is not enrolled in your COBRA plan, the section below must be completed by the parent, domestic partner, or spouse (the "Payee").

I, _____ (payee), authorize the San Bernardino County Employees' Retirement Association (SBCERA) to deduct from my monthly retirement benefit payment in the amount required to cover the COBRA monthly payment for my dependent, _____ (COBRA subscriber), including any future increases or decreases.

Payee's Signature _____ *Date* _____

For identification purposes, please provide one of the following:

Payee Employee No. **OR** *Last 4 digits of SSN:* _____

San Bernardino County
Human Resources Department
Employee Benefits and Services Division - COBRA
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San Bernardino, CA 92415-0440
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