

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 6-2000)

D

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

SECTION A

1. TYPE OF ACTION

NEW - ENROLLING IN A PLAN FOR THE FIRST TIME
(Complete Sections A, B, and D)

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES
(Complete Sections A, C, and D)

CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE
(Complete Sections A, B, C, and D)

2. SOCIAL SECURITY NUMBER

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER

4. NAME (First) (Middle) (Last)

ADDRESS (Number and Street)

(City, State, and Zip)

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE

6. MARITAL STATUS MARRIED SINGLE DOMESTIC PARTNER

7. SEX MALE FEMALE

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

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.

I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*

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. EMPLOYEE or COBEN DEDUCTION AMOUNT \$	4. PARTY CODE	5. STATE SHARE AMOUNT \$	6. PAY PERIOD MONTH YEAR	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
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

SECTION B

1. NAME OF DENTAL PLAN

2. PROVIDER/FACILITY NUMBER *(If applicable)*

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.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (include self)			DATE OF BIRTH			FAMILY RELATIONSHIP
	(First)	(Middle)	(Last)	MONTH	DAY	YEAR	
							SELF

19. AUTHORIZED AGENCY SIGNATURE
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.

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*

21. DATE RECEIVED IN EMPLOYING OFFICE
MONTH DAY YEAR