DENTAL ENROLLMENT FORM

Cajon Valley Union School District
Payroll, PO Box 1007, El Cajon CA 92022-1007
(619) 588-3070 FAX (619) 441-6170

The Federal Privacy Act of 1974 requires that you be notified that disclosure of your Social Security number is mandatory pursuant to the authority of the Cajon Valley Union School District under Article IX, Sec. 9 of the California Constitution. This record-keeping system was established prior to January 1, 1975. The Social Security number is used to verify your identity. The Cajon Valley Union School District will not disclose a recipient's Social Security number without the consent of the recipient, except as mandated by law.

Enroll	Chg	Drop	MARK PLAN CHOICE:
☐	☐	☐	Delta Dental **06714**
☐	☐	☐	DeltaCare USA

1st choice dental office #_____

2nd choice dental office #_____

Optional: At time of enrollment, you may choose a General Dental office (Facility) from the Directory of Participating Dentists. If your first choice is not available for new members, your second selection will be processed.

☐ I have been given the opportunity to apply for group dental insurance but DO NOT choose to elect this coverage.

EMPLOYEE'S LAST NAME	FIRST NAME MIDDLE	BIRTH DATE

STREET ADDRESS	CITY	STATE ZIP CODE

SOCIAL SECURITY NUMBER	☐ Male ☐Female	HOME PHONE

PLEASE INDICATE THE APPROPRIATE COVERAGE CATEGORY:
☐ Employee only ☐ Employee plus one dependent ☐ Employee plus family

EMPLOYEE CLASSIFICATION:
☐ Full time 6.75-8 hr/51-100% ☐ COBRA
☐ Part time 4-6.74 hr or CE 50% ☐ Retired

ACTION REQUESTED:
☐ New Enrollment ☐ Cancel Coverage ☐ Retiree Enrollment ☐ COBRA Enrollment ☐ Name/Address Change
☐ Change plans ☐ Add / Delete Dependents-legal documentation required ☐ Position chg - adj premiums

Reason: ☐ New Hire/Rehire ☐ Change in Hours ☐ Term/Retirement ☐ New/Drop dependent (lost eligibility) ☐ OPEN Enrollment
Are you or any of your dependents covered by another dental plan? ☐Yes ☐No _____
If yes, indicate who is covered: ☐ Self ☐ Spouse/Domestic Partner ☐ Dependent children **Insurance Carrier Name**

(Circle One)	DEPENDENTS (legal documentation required)	Gender	Birth Date	Social Security
1 Add / Drop	Spouse/California Registered Domestic Partner	M or F		
2 Add / Drop	Child	M or F		
3 Add / Drop	Child	M or F		
4 Add / Drop	Child	M or F		
5 Add / Drop	Child	M or F		

I desire to participate in the coverage selected above and hereby authorize my employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. A reproduction of this authorization shall be as valid as the original. Additionally, I understand this election will remain in effect unless a change is made during open enrollment, and may only be changed outside this time period if I experience a qualifying event as defined by federal regulation. Any person who knowingly and with intent to defraud any insurance company or other person, files an application or statement of claim containing any materially false information, or conceals for the purposes of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such as person to criminal and civil penalties. I understand any controversy between me and/or my enrolled dependents that cannot be resolved under this grievance procedure shall be settled by arbitration.

Employee Signature X _____ Date X _____

==========

Payroll Use Only:
☐ NEW ☐ CHANGE ☐ CURRENT ☐ CANCEL Event Date _____ **Effective Date** _____

Group #_____to #_____ ☐ Peoplesoft ☐ Ben Database ☐ AF Enroll Date Coupons Sent_____

Rev 09/2023