

DEPUTY SHERIFFS' ASSOCIATION OF SAN DIEGO COUNTY

13881 Danielson Street, Poway, CA 92064 www.dsasd.org

DENTAL AND VISION PLAN ENROLLMENT FORM

REQUISTED EFFECTIVE DATE OF COVERAGE / DATE OF CHANGE:																
QPEN ENPOLUMENT	CHECK THE APPROPRIATE BOXES															
NEW HIRE	REQUESTED EFFECTIVE DATE OF COVERAGE / DATE OF CHANGE: / / □ ENROLL □ CANCEL □										CHAN	GE				
MANE (LAST, FIRST, MIDDLE)	REASON:	OPEN ENROLLMENT	☐ ADDING	☐ ADDING DEPENDENT				☐ DIVORCE				☐ RETIREMENT				
NAME (LAST, FIRST, MIDDLE) SOCIAL SECURITY NUMBER APT/UNIT # CITY STATE ZIP PHONE MARITAL STATUS APT/UNIT # CITY STATE ZIP PHONE MALE FEMALE PPO DENTAL STATE STATE STATE STATE APT/UNIT # CITY STATE ZIP PHONE PROBLET STATE PPO DENTAL STATE STATE STATE PPO DENTAL PPO DENTAL PPO DENTAL STATE PPO DENTAL PPO DENTAL PPO DENTAL PPO DENTAL STATE STATE STATE STATE PPO DENTAL PROBLET STATE ST		□ NEW HIRE			☐ DELETING DEPENDENT				RIAGE							
NAME (LAST, FIRST, MIDDLE) SOCIAL SECURITY NUMBER APT/UNIT # CITY STATE ZIP PHONE MARITAL STATUS APT/UNIT # CITY STATE ZIP PHONE MALE FEMALE PPO DENTAL STATE STATE STATE STATE APT/UNIT # CITY STATE ZIP PHONE PROBLET STATE PPO DENTAL STATE STATE STATE PPO DENTAL PPO DENTAL PPO DENTAL STATE PPO DENTAL PPO DENTAL PPO DENTAL PPO DENTAL STATE STATE STATE STATE PPO DENTAL PROBLET STATE ST	EMPLOYEE IN	NEORMATION														
MARITAL STATUS				SOCIAL SECU	JRITY NUMBER	DAT	DATE OF BIRTH DATE OF HIR			IRF	DATE OF	RFTIRE	TIREMENT GENDER			
APT/UNIT #	(2.0.)															
MARITAL STATUS				,			, , ,				,	,				
MARITAL STATUS	ADDRESS			APT/LINIT #			CITY		STATE		7IP		PHONE			
SINGLE	ADDITESS			7.1.7,61111.11			317.112					1.1.0.1.2				
SINGLE	NAADITAL CTAT	FLIC	CL ACCI													
DIVORCED							DSA MEMBER NUMBER					EIVIAI	L ADDKE	55		
PRODUCT SELECTION SELECT A DENTAL AND VISION PLAN BY CHECKING THE BOX NEXT TO YOUR SELECTION. Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Per-Pay-Period Monthly Per-Pay-Period Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Per-Pay-Period Per-Pay-Period Monthly Per-Pay-Period Per-Pay-																
SELECT A DENTAL AND VISION PLAN BY CHECKING THE BOX NEXT TO YOUR SELECTION.			□ KEI	_ RETIRED												
CHECKING THE BOX NEXT TO YOUR SELECTION. Per-Pay-Period Monthly Monthly Per-Pay-Period Monthly Monthly Per-Pay-Period Monthly Monthly Per-Pay-Period Monthly Monthly Per-Pay-Period Per-Pay-Period Monthly Per-Pay-Period Monthly Per-Pay-Period Per-Pay-Period Monthly Per-Pay-Period P				\/(CI	ON				INAO DENI							
MEMBER ONLY																
MEMBER + 1			\bowtie	Per-Pay-Period Monthly					•	Monthly		\boxtimes		•	•	
MEMBER + 2 OR MORE	MEMBER ONLY									·						
MEMBER / DEPENDENT INFORMATION CHECK APPROPRIATE (LAST, FIRST, MI) CHAPROPRIATE BOX MEMBER SOCIAL SECURITY NUMBER SOCIAL SECURITY NUMBER RELATIONSHIP NUMBER MEMBER GENDER MALE GENDER MEMBER MALE MALE MEMBER MEMBER MEMBER MEMBER MEMBER MALE MEMBER MALE MALE MEMBER MEMBER MEMBER MALE MALE MEMBER MEMBER MEMBER MEMBER MALE MEMBER MEMBER MALE MEMBER MALE MEMBER MALE MEMBER MALE MEMBER MALE MEMBER MALE MEMBER MAME / CITY / GROUP # PATIENT MAME / CITY / GROUP # MAME / CITY / GROU	MEMBER + 1													•		•
CHECK APPROPRIATE BOX CANCEL CHANGE CHILD CHANGE CHANGE				\$9.89	\$21.41				\$18.67 \$40		.45	□ \$6		51.47 \$133.17		
APPROPRIATE BOX COVERAGE APPLIES NAME / CITY / GROUP # PATIENT																
ENROLL					RELATIONSHIP	GENDER										
ENROLL		(LASI, FIRSI, MII)	NUN	IBEK				(IVIIVI/DD/YYYY)				NAME / CITY / GROUP #				PATIENT
□ CHANGE □ DHMO □ NO □ CANCEL □ DPPO □ NO □ ENROLL □ SPOUSE □ MALE □ VISION □ YES □ CHANGE □ DOMESTIC □ FEMALE □ DHMO □ NO □ CANCEL □ DPPO □ YES □ PPO □ YES □ CHANGE □ DHMO □ NO □ NO □ CANCEL □ DPPO □ PPO □ YES □ ENROLL □ DPPO □ YES □ DHMO □ YES □ CHANGE □ CHILD □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO □ NO					NACNADED		7.4415									□ vec
□ CANCEL □ DPPO □ SPOUSE □ MALE □ VISION □ YES □ CHANGE □ DOMESTIC □ FEMALE □ DHMO □ NO □ CANCEL □ DPPO □ VISION □ YES □ CHANGE □ DHMO □ NO □ CANCEL □ DPPO □ NO □ CANCEL □ DPPO □ YES □ CHANGE □ DHMO □ YES □ CHANGE □ DHMO □ YES □ CHANGE □ DHMO □ NO					IVILIVIDEN						l					
□ ENROLL □ SPOUSE □ MALE □ VISION □ YES □ CHANGE □ DOMESTIC □ FEMALE □ DHMO □ NO □ ENROLL □ CHILD □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO □ CANCEL □ DPPO □ PPO □ ENROLL □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO							□ FEIVIALE			_						
□ CHANGE □ DOMESTIC □ FEMALE □ DHMO □ NO □ CANCEL □ DPPO □ DPPO □ PPO □ ENROLL □ CHANGE □ DHMO □ YES □ CANCEL □ DPPO □ PPO □ ENROLL □ CHILD □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO					☐ SPOUSE	Г	MAIF									□ VEC
□ CANCEL PARTNER □ DPPO □ STORDL □ VISION □ YES □ CHANGE □ DHMO □ DHMO □ NO □ CANCEL □ DPPO □ DPPO □ VISION □ YES □ CHANGE □ CHILD □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO □ NO																
□ ENROLL CHILD □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO □ CANCEL □ DPPO □ VISION □ YES □ ENROLL □ CHILD □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO							LIVIALL									
□ CHANGE □ DHMO □ NO □ CANCEL □ DPPO □ NO □ ENROLL □ CHILD □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO						Г	MALE									□ YES
□ CANCEL □ DPPO □ ENROLL CHILD □ MALE □ VISION □ YES □ CHANGE □ DHMO □ NO					311125											
□ ENROLL □ CHILD □ MALE □ VISION □ YES □ CHANGE □ FEMALE □ DHMO □ NO																
□ CHANGE □ DHMO □ NO					CHILD	Г	MALE									☐ YES
□ CANCEL □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	☐ CANCEL									☐ DPF						

CHECK APPROPRIATE BOX	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	RELATIONSHIP	GENDER	DATE OF BIRTH (MM/DD/YYYY)	WHICH COVERAGE APPLIES	DENTAL PROVIDER (DHMO) NAME / CITY / GROUP #	EXISTING PATIENT			
☐ ENROLL ☐ CHANGE ☐ CANCEL			CHILD	☐ MALE ☐ FEMALE		☐ VISION ☐ DHMO ☐ DPPO		☐ YES ☐ NO			
☐ ENROLL ☐ CHANGE ☐ CANCEL			CHILD	☐ MALE ☐ FEMALE		☐ VISION ☐ DHMO ☐ DPPO		☐ YES ☐ NO			
	DINATION / OTHER INSURA			//lata tha f	alla in a in farme						
Do you or your dependents have any other dental or vision insurance? If "Yes", complete the following information: BENEFIT INSURANCE COMPANY POLICY WHO IS COVERED UNDER THIS POLICY											
BENEFIT □ DENTAL □ VISION	INSURANCE COMPANY		-	OLICY #		WHO IS CO	VERED UNDER THIS POLICY				
☐ DENTAL ☐ VISION											
☐ DENTAL ☐ VISION											
SIGNATURES I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY EMPLOYER/ASSOCIATION TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.											
ARBITRATION DISCLOSURE: I agree that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and United HealthCare and PacifiCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.											
	(DATE)				(SIGNATURE)						