DEPUTY SHERIFFS' ASSOCIATION OF SAN DIEGO COUNTY
13881 Danielson Street, Poway, CA 92064
www.dsasd.org

DENTAL AND VISION PLAN ENROLLMENT FORM

CHECK THE APPROPRIATE BOXES

REQUESTED EFFECTIVE DATE OF COVERAGE / DATE OF CHANGE: / /			☐ ENROLL ☐ CANCEL ☐ CHANGE	
REASON:	☐ OPEN ENROLLMENT ☐ NEW HIRE	☐ ADDING DEPENDENT ☐ DELETING DEPENDENT	☐ DIVORCE ☐ MARRIAGE	☐ RETIREMENT

EMPLOYEE INFORMATION

NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	DATE OF HIRE (MM/DD/YYYY)	DATE OF RETIREMENT (MM/DD/YYYY)	GENDER ☐ MALE ☐ FEMALE

ADDRESS	APT/UNIT #	CITY	STATE	ZIP	PHONE

MARITAL STATUS	CLASSIFICATION	DSA MEMBER NUMBER	EMAIL ADDRESS
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	☐ ACTIVE ☐ RETIRED		

PRODUCT SELECTION

SELECT A DENTAL AND VISION PLAN BY CHECKING THE BOX NEXT TO YOUR SELECTION.	VISION			HMO DENTAL			PPO DENTAL		
	☒	Per-Pay-Period	Monthly	☒	Per-Pay-Period	Monthly	☒	Per-Pay-Period	Monthly
MEMBER ONLY	☐	$3.86	$8.35	☐	$6.46	$13.99	☐	$19.25	$41.70
MEMBER + 1	☐	$6.01	$13.01	☐	$12.27	$26.57	☐	$37.61	$81.47
MEMBER + 2 OR MORE	☐	$9.89	$21.41	☐	$18.67	$40.45	☐	$61.47	$133.17

MEMBER / DEPENDENT INFORMATION

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			MEMBER	☐ MALE ☐ FEMALE		☐ VISION ☐ DHMO ☐ DPPO		☐ YES ☐ NO
☐ ENROLL ☐ CHANGE ☐ CANCEL			☐ SPOUSE ☐ DOMESTIC PARTNER	☐ MALE ☐ FEMALE		☐ VISION ☐ DHMO ☐ DPPO		☐ YES ☐ NO
☐ ENROLL ☐ CHANGE ☐ CANCEL			CHILD	☐ MALE ☐ FEMALE		☐ VISION ☐ DHMO ☐ DPPO		☐ YES ☐ NO
☐ ENROLL ☐ CHANGE ☐ CANCEL			CHILD	☐ MALE ☐ FEMALE		☐ VISION ☐ DHMO ☐ DPPO		☐ YES ☐ NO

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

BENEFIT COORDINATION / OTHER INSURANCE CARRIER INFORMATION

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
☐ DENTAL ☐ VISION			
☐ 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)