



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

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	☐	\$3.02	\$6.54	☐	\$7.10	\$15.39	☐	\$19.20	\$41.60
MEMBER + 1	☐	\$5.68	\$12.30	☐	\$13.49	\$29.23	☐	\$37.51	\$81.27
MEMBER + 2 OR MORE	☐	\$8.68	\$18.80	☐	\$20.54	\$44.50	☐	\$61.31	\$132.84

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)

*Members who reside in any of the following states are eligible to enroll in the HMO Dental plan: AL, AZ, CA, CO, FL, GA, HI, ID, LA, MS, MT, NV, OH, OK, OR, SD, TN, TX, UT, VA, WA, WV, WY.