SWEETWATER UNION HIGH SCHOOL DISTRICT

ENROLLMENT and CHANGE FORM – DENTAL & VISION COVERAGE

FOR OFFICE USE ONLY ☐ Active ☐ Retired ☐ Leave

SSN:	Employee Name: Last	First	MI	DOB	Male ☐	Female ☐	Hire Date (for New Hires only)	Effective Date

Home Address	City	State	Zip Code	Home Phone	Employee ID #	Type of Change	Name ☐	Dependent ☐	Address ☐

COVERAGE SELECTION – Please indicate the dental plan in which you wish to enroll. Active employees eligible for dental **and** vision coverage must be in paid status in a monthly salaried position of half time or more. Eligible employees are automatically enrolled in vision coverage. Eligible dependents listed below will also be enrolled in vision coverage.

DENTAL PLANS

☐ Delta Dental PPO **(DENTAL PROVIDER NAME NOT NECESSARY WITH THIS PLAN)**

When enrolling in United Concordia DHMO, you MUST select a participating dental provider. When a provider is not selected, the carrier will randomly select one for you and your eligible dependents.

☐ United Concordia DHMO Dental Provider Name _____ Provider # ___ ___ ___ ___ ___ ___

DEPENDENT INFORMATION – Please list all of your eligible dependents for whom you wish coverage under the plan you have selected above.

		Last Name	First	MI	SSN#	Date of Birth	Relationship to Employee	
Add	Delete	Spouse/Domestic Partner					Spouse ☐ Domestic Partner ☐	Date of Marriage/Domestic Partner Registration?
Add	Delete	Child					Son ☐ Daughter ☐	Disabled ☐ Full Time Student ☐
Add	Delete	Child					Son ☐ Daughter ☐	Disabled ☐ Full Time Student ☐
Add	Delete	Child					Son ☐ Daughter ☐	Disabled ☐ Full Time Student ☐
Add	Delete	Child					Son ☐ Daughter ☐	Disabled ☐ Full Time Student ☐
Add	Delete	Child					Son ☐ Daughter ☐	Disabled ☐ Full Time Student ☐

AUTHORIZATION/AGREEMENT

I Deduction Authorization: I hereby authorize Sweetwater Union High School District to pay the dental benefits premiums for me and my eligible dependents (if applicable) to the plan checked above until changed or revoked by me in writing. I also authorize Sweetwater Union High School District to deduct from my salary the amount necessary, if any, to pay for my dental coverage not paid by the district and to transmit the same to the above-named plan.

II Authorization to Obtain or Release Medical Information (Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et.seq. of the California Civil Code): I hereby authorize my dentist, physician, health care practitioner, hospital, clinic, or other medical or medically-related facility to furnish an agent, designee, or representative of the dental plan in which I am enrolling as indicated above, any and all records pertaining to medical/dental history, services rendered, or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation, or evaluation of an application or a claim. I authorize such carriers or their agents, designees, or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical/dental information obtained, if such disclosure is necessary, to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to allow the processing of any claim.

III Arbitration Agreement: I understand that any dispute or controversy that may arise regarding the performance, interpretation, or breach of the agreement between myself (and/or any enrolled eligible dependent) and the Delta Dental PPO Plan or Safeguard Dental whether arising in contract, tort, or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

IV Dependent Coverage: I have read and understand the provisions on this form pertaining to dependents who are eligible to be included in my dental, and/or vision coverage. I hereby certify that the individuals listed on this enrollment form, if any, meet those provisions. Additionally, I understand that dependents not listed on this enrollment form may be added only by submitting appropriate forms to the Employee Benefits within 31 days of the date the dependent becomes eligible for coverage or during the annual open enrollment period held in the fall.

Employee's Signature _____ Date _____