175 West Fifth Street, San Bernardino, CA 92415-0440 | Phone: 909.387.5787 • Fax: 909.387.5566
www.SBCounty.gov

SAN BERNARDINO COUNTY

**Human Resources**
**Employee Benefits and Services**

| For Office Use Only | | | |
|---|---|---|---|
| Effective Date | Month | Day | Year |
| Group # | | | |
| Emp ID # | | | |

# Retiree Dental Plan Enrollment/Change Form

**A** ☐ NEW ENROLLMENT ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS

**B** I ELECT THIS DENTAL PLAN: ☐ Delta Dental PPO – Low* ☐ Delta Dental DPPO - High* ☐ DeltaCare USA HMO

*** Please note that the Delta Dental PPO plans is subject to a 12-month waiting period for restorative procedures if you are newly enrolled in the plan and have not had continuous group/employer sponsored dental coverage prior to enrolling in the plan.**

**C** **RETIREE INFORMATION OR RETIREE'S ELIGIBLE SURVIVOR INFORMATION**

| 1. Social Security No. | 2. Check One: ◯ Male ◯ Female | 3. Date of Birth Month Day Year | 4. Check One: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Domestic Partner |
|---|---|---|---|
| 5. Last Name | 6. First Name | 7. MI | 8. For Name Change, List Former Name Here |
| 9. Mailing Address Check Here If New Address | | 10. Primary Phone: ( ) Alternate Phone: ( ) | 11. Email |
| 12. City | 13. State | 14. Zip Code | 15. DeltaCare HMO members must provide the following: Provider Name_____ Provider No._____ |

**D** **NEW ENROLLMENT ONLY** **IF YOU ARE ENROLLING IN THIS DENTAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED**

| Last Name | First Name | Sex | Social Security No. | Date of Birth | Relationship |
|---|---|---|---|---|---|
| | | ☐ M ☐ F | | | |
| | | ☐ M ☐ F | | | |
| | | ☐ M ☐ F | | | |
| | | ☐ M ☐ F | | | |
| | | ☐ M ☐ F | | | |

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next Open Enrollment Period.

**E** **ENROLLMENT CHANGES ONLY** **IF YOU ARE ADDING OR DROPPING DEPENDENTS, LIST DEPENDENTS AND INDICATE EFFECTIVE DATE** **MONTH DAY YEAR** / /

| Name of family member(s) to be added or deleted: | Sex | Social Security No. | Date of Birth | Relationship |
|---|---|---|---|---|
| ☐ Add Spouse/Domestic Partner: ☐ Remove | ☐ M ☐ F | | | |
| ☐ Add Children: ☐ Remove | ☐ M ☐ F | | | |
| ☐ Add Children: ☐ Remove | ☐ M ☐ F | | | |
| ☐ Add Children: ☐ Remove | ☐ M ☐ F | | | |
| ☐ Add Children: ☐ Remove | ☐ M ☐ F | | | |

**F** **IF ADDING SPOUSE/DOMESTIC PARTNER, SHOW DATE OF MARRIAGE/DOMESTIC PARTNERSHIP. IF DELETING, SHOW DATE OF DIVORCE/DISSOLUTION OR DEATH;** **MONTH DAY YEAR** / / ☐ **DOMESTIC PARTNERSHIP** ☐ **DISSOLUTION** ☐ **MARRIAGE** ☐ **DIVORCE** ☐ **DEATH**

**G** **OTHER DENTAL COVERAGE**

Are you or any other member of your family covered by other group dental insurance? ◯ Yes ◯ No

Insurance company _____ Spouse's/Domestic Partner's employer _____

Policy no. _____ Phone number ( ) _____

**Please read and sign the back of this form**

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**H** **Employee Authorization:**

I hereby authorize my dentist, dental care practitioner, hospital, clinic, or other dental or dental-related facility to furnish any and all records pertaining to dental history, services rendered, or treatment given for purpose of review, investigation or evaluation of an application or a claim. I also authorize disclosure to a hospital or dental care plan, employer, self-insurer or insurer any such dental information obtained if such disclosure is necessary to allow the processing of any claims or for purposes of utilization review or financial audit. This authorization shall become effective immediately and shall remain in effect as long as it is necessary to enable claims processing.

**Dependent Affidavit:**

I understand and agree to each of the following:

- My enrolled dependent(s) meet the definition of an "eligible dependent" as defined in the Retiree Benefits Guide and plan eligibility requirements by carrier. *A complete list of dependent eligibility criteria may be found on the Human Resources Department - Employee Benefits and Services Division (HR-EBSD) internet site.*
- If I falsify dependent eligibility information to enroll an ineligible dependent, my dependent's coverage will be terminated in accordance with the provisions of the benefit plan contract. Any inconsistences discovered with respect to enrollment and eligibility will be investigated and appropriate action will be taken.
- The County reserves the right to request adequate documentation to assess a dependent's eligibility. Failure to submit requested information may result in immediate termination of the dependent's coverage from the County's group plans.
- It is my responsibility to:
- notify HR-EBSD within 60 days of the family status change date that would make one or more of my dependents ineligible for group health coverage
- provide supporting documentation upon request of HR-EBSD
- I am responsible for any applicable cost incurred for obtaining supporting documentation.
- The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively.
- If it is found that I am covering or have covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf.
- Failure to notify HR – EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for coverage for which your dependent was ineligible. Any refunds owed for such premiums are at the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County does not assume any liability resulting from terminating coverage of ineligible dependent(s).

By signing below, I certify and affirm to the County of San Bernardino that the dependent eligibility information submitted is true, correct, and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plan contracts, County policies, and related state and/or federal law(s).

By signing below:

- ✓ I elect to enroll in (or make the above changes to) the dental plan as shown above and authorize deduction to be made from my monthly retirement benefit payment to cover my share of the cost of enrollment as it is now or as it may be in the future. **Retirees who enroll in the Dental program are required to participate for a minimum of 24 consecutive months. Retirees who enroll in the Dental DPPO – High option are required to participate for a minimum of 24 consecutive months in DPPO – High option.**
- ✓ I certify and affirm to the County of San Bernardino that the dependent eligibility information submitted is true, correct, and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plan contracts, County policies, and related state and/or federal law(s).

Retiree's Signature _____ Date _____

Rev. 09/30/2025

**RETURN FORM TO:**

**County of San Bernardino**
**Employee Benefits and Services Division (EBSD)**
175 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 Fax (909) 387-5566