SPECIAL DENTAL PLAN ENROLLMENT FORM FOR NEWLY ELIGIBLE DEPENDENTS

Must print in Black or Blue ink ONLY

☐ **I AM ELECTING TO ADD MY NEWLY ELIGIBLE DEPENDENT(S) TO DELTA DENTAL PREMIER #3126-0124. I UNDERSTAND THERE IS NO ADDITIONAL COST FOR ADDING DEPENDENTS AT THIS TIME.**

EMPLOYEE INFORMATION

Last Name, First Name, MI	Employee ID	Social Security No.	Check One ☐ Male ☐ Female	Date of Birth

Mailing Address / Check box if new address ☐	City	State	Zip Code	Home: / Work:
Residential Address / Check box if new address ☐	City	State	Zip Code	Personal Email address:

ENROLLMENT CHANGES ONLY | **IF YOU ARE ADDING DEPENDENT(S) COMPLETE THIS SECTION.**

Enrollment Request Type	Last Name, First Name	Sex	Date of Birth	Social Security Number	Relationship
Add ☐	Children:	☐ M ☐ F			
Add ☐		☐ M ☐ F			
Add ☐		☐ M ☐ F			
Add ☐		☐ M ☐ F			

DELTA DENTAL

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 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.

EMPLOYEE AUTHORIZATION AND SIGNATURE

I agree to comply with the terms of the benefits group contracts in which I am enrolled. I also declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements and all eligible dependents listed as IRS Qualified dependents meet the IRC Section 152 definition of a qualified dependent. I will complete a new **County of Sonoma Employee Benefits Enrollment/Change Form within 31 days** of a change in this qualification or a change of benefit eligibility. I understand that the employee portion of the benefit premiums will be pre-tax only for IRS Qualified dependents. Further, I understand that I am responsible for the tax consequences (including interest and penalties) should there be any misstatement made on this declaration, or even in the absence of a misstatement, should the IRS or the State of California so determine that the benefits I am receiving for dependents listed as Qualified are found to be Non-Qualified. I authorize the County of Sonoma to withhold insurance premiums for the benefits requested in this document in accordance with the applicable Memorandum of Understanding or Board of Supervisor's resolution. I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge.

Employee Signature	**Date**

EMPLOYEE FORM

DISTRIBUTION: Original – HR-Benefits

FOR HR USE ONLY			
Keyed By (Employee ID)	Date	Pay Period Effective	Effective Date