



ACERA Dental Plan Enrollment Form

Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612
510-628-3000 or 1-800-838-1932, Press 1
www.acera.org

Check the reason for completing this form:

- Retirement
- Open Enrollment
- Qualifying Event
- COBRA

FOR ACERA USE ONLY

Input by:	Date:	Verified by:	Date:
Group Number:		Effective Date:	

Please print or type

MEMBER ENROLLMENT INFORMATION

Name: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Telephone No.: _____

TYPE OF CHANGE REQUESTED

- New Enrollment *Circle coverage type* Self Coverage* Self + 1 Coverage* Family Coverage*
- Change Coverage Type *Circle coverage type* Self Coverage* Self + 1 Coverage* Family Coverage*
- Change Dental Plan *Circle coverage type* Self Coverage* Self + 1 Coverage* Family Coverage*
- Cancel Dependent Coverage

* If you are adding, dropping, or changing dependent coverage, complete the Dependent Enrollment Information section below.

SELECT YOUR DENTAL PLAN

- Please review the *ACERA Enrollment and Health Plan Brochure* for plan details.
- For the DeltaCare USA plan, you must also select a dental office; otherwise, the provider will select one for you.

Delta Dental PPO Group #: 703-0001

DeltaCare USA Group #: 103-0001 —————> Select your dental office: _____

DEPENDENT ENROLLMENT INFORMATION

- List all eligible dependents to be covered by the Dental Plan. Attach an additional form, if adding more than three dependents.
- To enroll a dependent child between age 19 and 24, you must also submit an *ACERA Verification of Enrollment Status Form*.

Name	Social Security No.	Relationship	Male	Female	Date of Birth	Enroll	Cancel
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>

I am **declining** dependent dental coverage. I understand that if I do not enroll my eligible dependents at this time or if I choose to discontinue coverage at a later date, there may be no provisions to re-enroll during future ACERA Open Enrollment periods.

MEMBER AUTHORIZATION AND SIGNATURE

- ALL RETIRED ACERA MEMBERS ARE AUTOMATICALLY ENROLLED IN A DENTAL PLAN. COVERAGE FOR NON-ACERA MEMBERS (I.E. SPOUSE, DOMESTIC PARTNER, DEPENDENT) IS VOLUNTARY AND PREMIUM COSTS WILL BE DEDUCTED FROM THE RETIREMENT ALLOWANCE.
- I AGREE TO HAVE MY RETIREMENT ALLOWANCE REDUCED BY THE AMOUNT NEEDED TO PAY MY COST AND/OR MY SPOUSE'S/DOMESTIC PARTNER'S/DEPENDENT'S PREMIUM COST(S) FOR THE DENTAL PLAN, AS INDICATED ABOVE. I ALSO AUTHORIZE THE PLAN OR CARE PROVIDER TO RELEASE ANY OR ALL MEDICAL INFORMATION FOR MYSELF OR COVERED FAMILY MEMBERS WHEN INFORMATION IS NEEDED TO PROCESS DENTAL PLAN CLAIMS.
- I UNDERSTAND THAT THE ACERA BOARD OF RETIREMENT RESERVES THE RIGHT TO MODIFY AND/OR CANCEL MEMBER DENTAL COVERAGE. I UNDERSTAND THAT THE BENEFITS OF THE PLAN I CHOOSE ARE COORDINATED WITH THOSE PROVIDED UNDER ANY OTHER GROUP HOSPITAL, MEDICAL BENEFIT, OR DENTAL.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR A GREATER PORTION OF MY COSTS WHEN I USE A NON-PARTICIPATING PROVIDER FOR DELTA DENTAL PPO. THERE IS NO REIMBURSEMENT WHEN A NON-DELTACARE USA PROVIDER IS USED.
- I ELECT TO BE COVERED UNDER THE OPTION I HAVE CHECKED ABOVE. I UNDERSTAND THAT MY ELECTION MAY ONLY BE REVOKED IN WRITING. I HAVE READ AND UNDERSTAND ALL OF THE ABOVE.

Signature: _____ Date: _____



ACERA Dental Enrollment Form Instructions

Please review the current *ACERA Enrollment and Health Plan Brochure* for details about your dental plan coverage.

On the next page, you will find the ACERA Dental Enrollment Form. If you would like to make changes to your dental coverage, complete and submit this Enrollment Form to ACERA by the 10th of the month in order to have coverage effective the following month. If you are making changes during Open Enrollment, be sure to return your form(s) to ACERA by December 1. Mail your form to:

ACERA
475 14th Street, Suite 1000
Oakland, CA 94612
Attn: Retired Benefits Unit

HERE ARE INSTRUCTIONS FOR COMPLETING THIS FORM:

MEMBER ENROLLMENT INFORMATION

- Fill in your name, Social Security number, and demographic information. This information will be sent to the provider and is necessary to enroll you in the plan.

TYPE OF CHANGE REQUESTED

- Check the box indicating the type of dental plan change you are requesting. If this is a new enrollment or a change in your dental plan coverage (switching dental plans, adding or dropping dependents), indicate by circling coverage type (i.e. Self, Self + 1, or Family if enrolling more than 1 dependent).

SELECTING YOUR DENTAL PLAN

- Check the box by the plan name you have selected.
 - If you are currently enrolled in the Delta Dental Buy-Up PPO Plan, you must select a different plan and complete this enrollment form.
 - You and your dependents must be enrolled in the same plan.
 - Delta Dental PPO is available at any dental office that accepts Delta Dental; however, coverage levels and amounts differ and are based on in-network and out-of network participation.
 - DeltaCare USA is similar to a health plan HMO in that you must select a dental office when selecting this plan. If selecting DeltaCare USA indicate on the line your preferred dental office. All dental services must be received from that office.

DEPENDENT ENROLLMENT INFORMATION

- List the name, Social Security number, relationship, and birth date for all dependents you are either adding or dropping. Additionally, check the box to indicate if you are enrolling or canceling coverage for that dependent.
- If you are enrolling in the plan but are declining dependent dental coverage at this time, please check the decline/cancel box.

MEMBER AUTHORIZATION AND SIGNATURE

- Carefully read each bullet point.
- Sign and date the form.
- Keep the yellow copy for your records.
- Mail the white copy to ACERA.

Turn the page to make changes ►