Dental Plan Enrollment Form

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475 14th Street, Suite 1000
Oakland, CA 94612

If you retired with 10 or more years of ACERA service credit or with a service-connected disability retirement with any amount of service credit, you must complete and submit this form or ACERA will choose a plan for you. If you retired with less than 10 years of ACERA credit, you may voluntarily submit this form in order to enroll in a plan.

SECTION 1 Member Information

Your Name (First Name, Middle Initial, Last Name) _____ Social Security Number _____

Physical Home Address _____

City _____ State _____ ZIP _____

Birth Date (mm/dd/yyyy) _____ ☐ Male ☐ Female ☐ Unknown

Gender

Personal Email Address _____ Phone _____

SECTION 2 Reason for Enrollment Form

Choose one:

☐ Enroll in Dental Coverage

☐ Change Dental Coverage

☐ Add or Drop Dental Coverage for Dependent

☐ Cancel Coverage _____

Last Day of Coverage Requested

SECTION 3 Enrollment Event

Choose one:

☐ Open Enrollment

☐ Retirement (enter date below)

☐ Moved Out of Service Area (enter date below)

☐ Loss of Coverage (enter date below)

☐ Life Event Change (marriage/divorce/death/other) (enter date below)

Retirement, Moving, Loss of Coverage, or Family Change Date: _____

Put your name and Last 4 of SSN or ACERA ID at the top of every page

Your Name (First Name, Middle Initial, Last Name) | Social Security Number

SECTION 4 Level of Coverage

Choose one:

☐ Self Coverage

☐ Self+1 Coverage

☐ Family Coverage

SECTION 5 Select Your Dental Plan

Review the ACERA Retiree Enrollment Guide for plan details: www.acera.org/guide.
Review plan costs here: www.acera.org/dental.

☐ Delta Dental PPO **Group No. 703** (Nationwide Plan)

☐ DeltaCare USA **Group No. 103** (California only)

You must also select a dental office. Otherwise, the provider will be selected for you.

Select your dental office: _____

SECTION 6

Dependent Information

- If you're adding a Domestic Partner, you must also submit an Affidavit of Domestic Partnership: www.acera.org/adp.
- You must submit an Affidavit of Dependent Eligibility if enrolling a dependent other than your spouse or domestic partner who is:
  - Ages 19-25
  - Age 26 and older if incapable of supporting themselves due to a mental or physical disability incurred prior to age 26.
    www.acera.org/ade

Name	Last 4 of SSN	Birth Date	Relationship	Gender*
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U

*M=Male, F=Female, U=Unknown

Put your name and Last 4 of SSN or ACERA ID at the top of every page

Your Name (First Name, Middle Initial, Last Name) | Social Security Number

SECTION 7 Authorization and Signature

Please keep a copy for your records

- I understand it is unlawful to knowingly (1.) provide false information to receive, reduce, or deny any benefit to myself or any person and(2.) accept and/or retain payment from a retirement system that the recipient is not entitled to. *See note on instruction page.
- I agree to have my retirement allowance reduced by the amount needed to pay my cost, if applicable, 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 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 plan.
- I understand I am responsible for a greater portion of my costs when I use a non-participating provider under the Delta Dental PPO plan. 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 my election may only be revoked in writing. I have read and understand all of the above.

Member Signature | Date (mm/dd/yyyy)

For ACERA Use Only

Division Number: | Effective Date: