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
Fax: 510-268-9574 www.acera.org

Check the reason for completing this form:
☐ Retirement ☐ Loss of Coverage ☐ Change Plans
☐ Open Enrollment ☐ COBRA Event Date: _____

ACERA USE ONLY Division #: Effective Date:

Member Enrollment Information **Please print or type**

Name: _____ Social Security No.: _____

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

Date of Birth: _____ Gender: ☐ Male ☐ Female Phone No.: _____

Type of Change Requested

☐ New Enrollment → ***Select ONE coverage type:*** ☐ Self Coverage ☐ Self + 1 Coverage* ☐ Family Coverage*

☐ Add Dependent Coverage

☐ Cancel Dependent Coverage

☐ Change Dental Plans

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

Select Your Dental Plan

- Please review the *ACERA Retiree Enrollment Guide* for plan details.
- DeltaCare USA plan: **You must also select a dental office. Otherwise, the provider will be selected for you.**

☐ Delta Dental PPO Group #: 703

☐ DeltaCare USA Group #: 103 ⟶ Select your dental office: _____

Dependent Enrollment Information **List all eligible dependents. Attach additional forms if necessary.**

- To enroll a dependent child who is age 19 to age 26, you must submit an *ACERA Affidavit of Dependent Eligibility* form, which can be found on ACERA's website at www.acera.org
- If adding dependents, submit the necessary documentation such as marriage certificate, birth certificate, etc.

Name	Social Security No.	Relationship	Male	Female	Date of Birth	Add	Cancel
			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐

☐ I am **declining** dependent dental coverage. I understand 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

- 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.

Signature: _____ **Date:** _____

ACERA Dental Enrollment Form Instructions

Please review the current *ACERA Retiree Enrollment Guide* for details about your dental plan coverage. Annual maximums are based on enrollment and networks used or not used.

On the next page is the ACERA Dental Enrollment Form. If you would like to enroll or make changes to your dental coverage, complete and submit this 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, return your form(s) to ACERA by November 30. Mail your form to:

ACERA
Attn: Call Center
475 14th Street, Suite 1000
Oakland, CA 94612

Note: The County Employees' Retirement Law of 1937, as amended, provides that is unlawful to make or cause to be made, or present any knowingly false material statement or material misrepresentation, to knowingly fail to disclose a material fact, or otherwise provide false information with the intent to use it, or allow it to be used, to obtain, receive, continue, increase, deny or reduce any benefit to any person. As well, it is unlawful to knowingly accept or obtain payment from a retirement system with knowledge that the recipient is not entitled to the payment and to retain the payment for personal use or benefit.

Member Enrollment Information

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

Type of Change Requested

- Check the "New Enrollment" box and *select coverage type* if you currently have no dental coverage through ACERA.
  - **If you are a member with less than 10 years of service who is electing new coverage, select New Enrollment, as you are entering into a voluntary plan.**
- Check the "Add Dependent Coverage" box if you want to add an eligible dependent to your dental coverage.
- Check the "Cancel Dependent Coverage" box if you want to cancel your dependent's dental coverage.
- Check the "Change Dental Plans" box if you want to change to/from the Delta Dental PPO to/from the DeltaCare USA plan.

Select Your Dental Plan

- Check the box by the plan name you have selected.
  - **Delta Dental PPO** is available at dental offices accepting Delta Dental; however, coverage levels and amounts differ and are based on in-network and out-of network dentist participation. Note: there is a lower annual maximum benefit provided when using a Premiere dentist vs. a PPO in-network dentist
  - **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

- Review the section titled, "Enrolling Your Eligible Dependents" in the *ACERA Retiree Enrollment Guide* for the definition of a dependent and the requirements for adding, canceling, or retaining a dependent to/from your coverage. You and your dependents must be enrolled in the same dental plan.
- List the name, Social Security number, relationship, and date of birth for each dependent. Additionally, check the box to indicate if you are adding or canceling coverage for that dependent.
- If your dependent is age 19 to age 26, complete and attach an *ACERA Affidavit of Dependent Eligibility* form, which can be found on ACERA's website at www.acera.org. This is an annual requirement during Open Enrollment.
- Attach supporting documents, if your dependent is disabled.
- If you are enrolling in the dental plan but are declining dependent dental coverage at this time, please check the "I am declining dependent dental coverage" box.

Member Authorization And Signature

- Carefully read each bullet point.
- **Sign and date the form.**
  - *If a Durable Power of Attorney (POA) or Legal Guardian/Conservatorship helped complete this form, then he/she must sign it and attach a copy of the applicable court order or POA document establishing authority to act on your behalf, if not already on file with ACERA*
- Keep a copy of the form for your records.
- Mail the completed form to ACERA.

Turn the page to make changes ►