



Dental and Vision Plan

New Enrollment/Change/Cancellation

Instructions

Section I: Membership Information

Fill in the personal information requested.

Section II: Reason

Check the box next to the reason you are completing this form (i.e., new enrollment, change dental plan, change of address, etc.).

Section III: Dental/Vision Plan Information

Check the box next to the dental/vision combination in which you want to enroll, and the box(es) next to those you want to cover.

Section IV: Family Information

Fill in the information requested for yourself and any eligible dependents you want to cover.

Print your last name, first name, middle initial and Social Security number at the top of the second page.

Section V: Read and Understand/Authorization

Carefully read each paragraph. Sign and date the form at the bottom on the lines provided.

LACERA treats your and your family's personal health information as confidential. We follow the applicable sections of HIPAA related to privacy and security of your protected health information. If you have any questions about the steps taken to secure your protected health information, please refer to the HIPAA policy posted on the LACERA website, www.lacera.com.



DENTAL AND VISION PLAN



New Enrollment Change Cancellation

Los Angeles County Employees Retirement Association, PO Box 7060, Pasadena, CA 91109-7060

(FOR LACERA USE ONLY)

Retirement Date _____	Effective Date _____	Years of Service _____	Current: D/V: _____	Deduction Code
<input type="checkbox"/> SCD	<input type="checkbox"/> NSCD	Input Date _____	New: D/V: _____	
			Premium: D/V: \$ _____	

Please check one: Completed by Retiree Survivor COBRA Participant

SECTION I: Membership Information

Last Name (Print)		First Name (Print)		M.I.	Social Security Number
Street Address		Apt.	Date of Birth		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	ZIP Code	Home Phone Number ()		Work Phone Number ()
Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner: Date of Marriage/Registration _____			<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership Terminated: Date of Divorce/Termination of Domestic Partnership _____		
			<input type="checkbox"/> Widowed: Date of Death _____		

SECTION II: Reason

- New enrollment (Go to Sections 3 and 4)
- Change dental plan (Go to Sections 3 and 4)
- Cancel dental/vision coverage (Go to Section 4)
- Add family member (Go to Section 4)
- Delete family member (Go to Section 4)
- Moving out of service area of CIGNA Dental Health.
- Name change: Former Name _____ (write new name in Section 1)
- Address change: Former Address _____ (write new address in Section 1)
- Re-enrollment for (check all that apply) Surviving spouse Domestic partner Dependent children
Name of Deceased Retiree _____ Social Security Number _____
- Other: Explain _____

SECTION III: Dental/Vision Plan Information

Please check the boxes that apply to you:

Plan

- I wish to enroll in the CIGNA Indemnity Dental/Vision Plan.
- I wish to enroll in the CIGNA Dental HMO/Vision Plan.

Who Will Be Covered

- Myself Dependent(s)
- Myself Dependent(s)



