Dental and Vision Plan

New Enrollment/Change/Cancellation

Instructions

Please be sure to fill in ALL the required areas and provide ALL the required/ necessary documents. Any missing information will cause a delay in processing this form.

Section 1: Membership Information

Check the appropriate box on the top of the form and fill in the personal information requested.

Section 2: 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 3: 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 4: 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 5: Read and Understand/Authorization

Carefully read each paragraph. Sign and date the form at the bottom on the lines provided and return the completed form to:

LACERA
P.O. Box 7060
Pasadena, CA 91109-7060

Remember to keep the bottom copy for your records.

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.

Los Angeles County Employees Retirement Association
PO Box 7060
Pasadena, CA 91109-7060
www.lacera.com

DENTAL AND VISION PLAN D CD

Please check one of the following boxes:
☐ New Enrollment ☐ Change ☐ Cancellation

(FOR LACERA USE ONLY) **EFFECTIVE DATE** ______________ **Deduction Code**

Retirement Date ______________ Years of Service __________ Current D/V: ______________
☐ SCD ☐ Tier 1 Fax Date ____________ Input Date ____________ New D/V: ______________
☐ NSCD ☐ Tier 2 ☐ PPA Initials Form # __________ Initials ________ Premium D/V: $______________

SECTION I: Membership Information

Please check one: Completed by ☐ Retiree ☐ Survivor ☐ COBRA Participant

Last Name	First Name	M.I.	Social Security Number

Street Address	Apt.	Date of Birth	Sex: ☐ Male ☐ Female

City	State	ZIP Code	Contact Phone Number	Alternate Phone Number

Email Address

Marital Status (check one) ☐ Single
☐ Married, date of marriage __________ ☐ Divorced, date of divorce/legal separation ______ ☐ Widowed, date of death _______
☐ Domestic Partner, date of registration ___________ ☐ Domestic Partnership Terminated, date of termination ___________

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 HMO
☐ **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	Who Will Be Covered	
☐ I wish to enroll in the **Cigna Indemnity Dental/Vision Plan**.	☐ Myself	☐ Dependent(s)
☐ I wish to enroll in the **Cigna Dental HMO/Vision Plan**.	☐ Myself	☐ Dependent(s)

Last Name	First Name	M.I.	Social Security Number

SECTION IV: Family Information

Please provide the requested information for yourself and all covered dependents.

Relationship	Last Name	First Name	M.I.	SSN	Date of Birth	Sex (M/F)	For Cigna Dental HMO select a dental office		Dental/ Vision Coverage
							1st Choice	2nd Choice	
Retiree/ Survivor						☐ M ☐ F			☐ Yes ☐ No
Spouse/ Domestic Partner*						☐ M ☐ F			☐ Yes ☐ No
Dependent Child**						☐ M ☐ F			☐ Yes ☐ No
Dependent Child**						☐ M ☐ F			☐ Yes ☐ No
Dependent Child**						☐ M ☐ F			☐ Yes ☐ No

* To cover your eligible spouse/dependent children/domestic partner, you must provide the original marriage certificate/birth certificate/ Certificate of Registration of Domestic Partnership from the State of California. After verification, the original will be returned to you.

** Please attach a copy of legal document for your adopted children.

☐ Please check here if you or eligible members of your family are currently patients at any of the dental offices selected above.

SECTION V: Read and Understand/Authorization

I understand that any dispute, including dental malpractice claims, between me (or someone with a relationship to me) and Connecticut General Life or Cigna Dental Health, their contracting providers or the dentists or employees of any of them, may be subject to the grievance procedures outlined in my Plan Booklet.

I hereby enroll for the Dental and Vision Coverage indicated above. I authorize the Los Angeles County Employees Retirement Association (LACERA) to make the necessary deductions from my retirement warrants for any contributions required of me and to send these contributions to the company chosen by me. I understand the LACERA Board of Retirement reserves the right to amend, revise, or discontinue these plans and programs at anytime.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO REPORT ANY CHANGE IN THE ELIGIBILITY OF MYSELF AND/OR MY ELIGIBLE DEPENDENTS TO LACERA IN WRITING WITHIN 30 DAYS OF THE CHANGE.

I also understand that all of the benefits of these plans are coordinated with benefits provided by any other group, hospital or medical benefit or service plan, including Medicare.

I hereby authorize any dentist, oral surgeon, practitioner or other person, any hospital including any medical service organization, insurance company or any other institution to release to each other any healthcare or other information about me or my dependents, including benefits paid or payable, on any sickness or illness that I now have or may sustain. I further authorize Connecticut General Life or Cigna Dental Health to release any records, data or information concerning me or my dependents to its designee for purposes of plan administration and customer service.

Signed ____ Date________________

*Your signature or signature of guardian, conservator or power of attorney**

Your Spouse's/Domestic Partner's Signature ____________________ Date ________________

*Your spouse's/domestic partner's signature or signature of guardian, conservator or power of attorney**

* If this is submitted by a guardian or conservator, please attach the legal document establishing guardianship, conservatorship or the power of attorney to this form. Keep the last copy for your records. Return the top copy along with any other appropriate forms to LACERA.