How to Complete Your Dental and Vision Plan CHANGE Form – With SAMPLE

Follow the instructions below and refer to the attached sample to help you fill out and submit your dental and vision change form. Any missing information or documentation will cause a delay in processing your form. The sample provides detailed instructions for each of the different form sections.

How to Complete Your Form

Fill in **all** the required areas, referring to the sample form. All dental/vision forms must be completed by the retiree, survivor, or guardian/ conservator/attorney-in-fact

You will need the following to fill out your form (as applicable):

- Social Security numbers for the enrollee and any dependents
- Dates of birth, marriage, partnership, divorce/termination of partnership, or death for the enrollee and any dependents

If you have questions or need help with completing the form, call us at 800-786-6464

How to Submit Your Form

Your completed form must be **physically signed** (even if you complete the fillable PDF form). **No electronic signatures are accepted at this time.**

You must provide **all** the required documentation when submitting your form in order for your plan change to be processed.

You will need to provide the following documentation with your form, as applicable:

- **For spouses or partners:** photocopy of original marriage certificate or domestic partnership with the California Secretary of State
- **For eligible dependent children:** photocopy of original certified birth certificate
- **Photocopies of certificates must be accompanied by a signed attestation** certifying that the photocopy is a true and correct copy of the certificate and contains no alterations from the original
- **For adopted children:** certified copy of the adoption order
- **For handicapped children:** current physical or mental handicap verification form, physician statement, proof of continuous coverage for handicapped child, and proof of financial support
- **For guardians, conservators, or attorneys-in-fact:** legal document designating the individual authorized to act on member's behalf

To submit your form and documentation:

- **Scan and upload** your forms to My LACERA via lacera.com (*recommended*). This is the fastest method of submission, and you will receive a confirmation of receipt. **OR**
- **Mail** your forms to LACERA, P.O. Box 7060 Pasadena, CA 91109-7060. **OR**
- **Fax** your forms to 626-564-6155. **OR**
- **Drop off** your forms in the secure drop-box outside our Member Service Center at 300 N. Lake, Pasadena, CA 91101.

Remember to keep a 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.

LACERA

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 (1) ☐ 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: $_____

(1) Select the Change box.
Do not complete the gray section. (FOR LACERA USE ONLY)

Section 1

SECTION I: Membership Information

(2) Please check one: Completed by ☐ Retiree ☐ Survivor ☐ COBRA Participant

Last Name	First Name	M.I.	Social Security Number
DOE	JANE	A	XXX-XX-XXXX

(3)

Street Address	Apt.	Date of Birth	Sex: ☐ Male ☐ Female
ADDRESS		XX-XX-XXXX	

City	State	ZIP Code	Contact Phone Number	Alternate Phone Number
ADDRESS	ADDRESS	ADDRESS	(XXX) XXX-XXXX	(XXX) XXX-XXXX

Email Address

(4) 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 _____

(2) Check the appropriate box **(one box only)**.
*COBRA participants: Check **only** the COBRA participant box.*

(3) Fill in information where requested. If updating your name or address, fill in your **new/current** information.

(4) Check the appropriate marital status box and fill in dates where requested.

Section 2

SECTION II: Reason

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☐ **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

(Please select appropriate reason for change)

☐ **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 _____

5 Check the box next to the reason you are completing this form and fill in any requested information.

If adding or deleting a family member, you do not need to complete Section 3. Go to Section 4.

Section 3

SECTION III: Dental/Vision Plan Information

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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)

6 Check the box next to the dental/vision plan in which you want to enroll, and who will be covered. You and your dependent must be enrolled in the same plan.

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DOE	JANE	A	XXX-XX-XXXX
Last Name	First Name	M.I.	Social Security Number

7 On the top of page 2, be sure to provide your last name, first name, middle initial, and Social Security number in the space provided.

Section 4

SECTION IV: Family Information

8 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)	9 For Cigna Dental HMO select a dental office: 1st Choice	2nd Choice	10 Dental/ Vision Coverage
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.

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

8 Provide the requested information for yourself and all covered dependents (last name, first name, middle initial, Social Security number, date of birth, and sex).

9 For information, please contact Cigna Dental: 800-244-6224; www.mycigna.com

10 Be sure to check the coverage box next to the dental/vision enrollee(s) who will be covered.

11 Check the box if you or your eligible family members are currently patients at one of your selected dental offices.

Section 5

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.

12 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.

12 Sign and date change form. *Your completed form must be **physically signed.** No electronic signatures are accepted at this time.*