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

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Follow the instructions below and refer to the attached sample to help you fill out and submit your dental and vision enrollment 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](http://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](http://www.lacera.com).



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

## DENTAL AND VISION PLAN **D**

Please check one of the following boxes:  
**1** ☒ **New Enrollment** ☐ **Change** ☐ **Cancellation** **CD**

<b>(FOR LACERA USE ONLY)</b>		<b>EFFECTIVE DATE</b> _____	<b>Deduction Code</b>
Retirement Date _____		Years of Service _____	Current D/V: _____
<input type="checkbox"/> SCD <input type="checkbox"/> Tier 1	Fax Date _____	Input Date _____	New D/V: _____
<input type="checkbox"/> NSCD <input type="checkbox"/> Tier 2 <input type="checkbox"/> PPA Initials	Form # _____	Initials _____	Premium D/V: \$ _____

**1** Select the New Enrollment box.

*Do not complete the gray section. (FOR LACERA USE ONLY)*

## Section 1

<b>SECTION I: Membership Information</b>					
<b>2</b> Please check one: Completed by <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor <input type="checkbox"/> COBRA Participant					
Last Name DOE		First Name JANE		M.I. A	Social Security Number XXX-XX-XXXX
Street Address ADDRESS			Apt.	Date of Birth XX-XX-XXXX	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City ADDRESS	State ADDRESS	ZIP Code ADDRESS	Contact Phone Number (XXX) XXX-XXXX	Alternate Phone Number (XXX) XXX-XXXX	
Email Address					
<b>4</b> Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married, date of marriage _____ <input type="checkbox"/> Divorced, date of divorce/legal separation _____ <input type="checkbox"/> Widowed, date of death _____ <input type="checkbox"/> Domestic Partner, date of registration _____ <input type="checkbox"/> 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

5

☒ **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 \_\_\_\_\_

5 Check the New Enrollment box and go to Section 3.

Section 3

SECTION III: Dental/Vision Plan Information

6

Please check the boxes that apply to you:

Plan	Who Will Be Covered
<input type="checkbox"/> I wish to enroll in the <b>Cigna Indemnity Dental/Vision Plan</b> .	<input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)
<input type="checkbox"/> I wish to enroll in the <b>Cigna Dental HMO/Vision Plan</b> .	<input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)

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

7	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.

9

10

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						<input type="checkbox"/> M <input type="checkbox"/> F	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/ Domestic Partner*						<input type="checkbox"/> M <input type="checkbox"/> F	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**						<input type="checkbox"/> M <input type="checkbox"/> F	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**						<input type="checkbox"/> M <input type="checkbox"/> F	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**						<input type="checkbox"/> M <input type="checkbox"/> F	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<input type="checkbox"/> Yes <input type="checkbox"/> 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](http://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 enrollment form. *Your completed form must be **physically signed**. No electronic signatures are accepted at this time.*