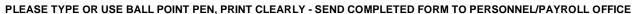
## **DENTAL PLAN ENROLLMENT AUTHORIZATION**

CSU 692 (RV. 12/2023)



<b>7</b>

SECTION A	THE OR OOL BALL			SECTION B										
1. TYPE OF ACTION					1. NAME OF DENTAL PLAN									
NEW - ENROLLING	NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D)					2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only)								
CANCEL – (Complete Sections A, C, D)														
CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D				3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDES THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.										
2. NAME (First) (Middle) (Last)			ACTION CODE		IN C	L PERSONS TO BE DENTAL PLAN (Inc (Middle) (Las	lude self)	DATE O BIRTH (MM/ DD/ \	DEPE	NDENT YPE	GENDER			
ADDRESS (Number and Street)					(****	7	(11121)		<u>(                                    </u>		ELF			
(City, State, and Zip)														
3. MARITAL STATUS	4. <b>G</b>	SENDER			SSN									
MARRIED	SINGLE	MALE FEMALE			SSN									
DOMESTIC PARTNER					-									
		NON-BINARY			SSN									
5. SOCIAL SECURITY	NUMBER 6. SPOUSE'S OF		CIAL SECURITY NUMBER											
					SSN									
SECTION C					SSN									
1. PRIOR DENTAL PI	LAN NAME				0014									
					SSN									
SECTION D - EMPL	OYEE AND EMPLOYE	ER AUTHORIZATION												
				SSN										
I. CHECK APPROPRIATE BOX  I AM WAIVING ENROLLMENT IN A DENTAL PLAN (Also applicable to enrollment in FlexCash Dental)  Output  Dental)				Dependent Type: S - Spouse C - Child DPC - Domestic Partner Child DP - Domestic Partner SC - Stepchild PCR - Parent-child Relationship										
I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE PRE-TAX DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE (IF APPLICABLE) OF THE COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE CALIFORNIA STATE UNIVERSITY AND ARE NOT ENROLLED IN ANOTHER STATE CALIFORNIA DENTAL PLAN.  I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.														
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE (See Privacy Information on reverse of employed)					/)			3. DATE SIGNE	D					
SECTION E (FOR A	AGENCY OR RETIRE	EMENT SYSTEM U	SE ONLY)											
1. CSU DED.CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD		CSU SHARE AMOUNT		6. EMPLOYEE DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATIO		8. BARGAINING UNIT		9. TOTAL PREMIUM AMOUNT		
CSU-150			MONTH YEAR	\$			\$					\$		
COMPLETE ON CHAN	COMPLETE ON CHANGES ONLY		13. PERMITTING		FECTI	VE	15. AGENCY	16. UNIT CODE	17 0	17. CAMPUS NAME (IF ACTIV		CTIVE		
10. PRIOR EMPLOYER 11. PRIOR PRIOR (MM		12. PERMITTING EVENT DATE ( MM / DD /YY )	EVENT CODE	DATE OF ACTION		=	CODE	10. GIVIT GODE		EMPLOYEE)		,,,, <u>,</u>		
DED. CODE CSU-150	DENTAL PARTY ORG. CODE	CODE MONTH DAY YEAR		MONTH DAY YEAR						<b>-</b>		<b>7</b>		
NON-CSU-351	CODE			IVICIAL	1				CAL	PERS RETI	REE?	YES		
18 REMARKS				19.	1 AUTHO	DRIZED	CAMPUS BENEFIT	S OFFICE SIGNE	ER (PLEAS	E PRINT)	L	NO		
-														
					20. AUTHORIZED CAMPUS BENEFITS OFFICER SIGNATURE I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting Benefits officer or authorized campus designee and that I am authorized to make this certification; that the employees (and any named dependents) named herein is eligible for enrollmen in the CSU Dental Program.									
				21. TELEPHONE NUMBER (Include Area Code)					22. DATE RECEIVED IN EMPLOYING OFFICE					
				23.	23. EMAIL ADDRESS					Month	Day 	Year		

## **DENTAL PLAN ENROLLMENT AUTHORIZATION**

CSU 692 (REV. 12/2023)(REVERSE)

## PRIVACY NOTICE

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Information requested on this form is used by the State Controller's Office and the dental insurance company for the purposes of identification and dental coverage processing.

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

- 1. Enrollee identification
- 2. Payroll deduction/state contributions
- 3. Billing of contracting agencies for employee/ employer contributions
- 4. Reports to CalPERS and other state agencies
- 5. Coordination of benefits among carriers
- 6. Resolving member appeals, complaints, or grievances with health plan carriers

Information provided on the form will be forwarded to the dental insurance company providing coverage for the employee. Copies of the Dental Plan Enrollment Authorization are maintained in confidential files of Campus Benefits Office for ten years. Employees have the right to access copies of their Dental Plan Enrollment Authorization forms upon request. Send requests to: your Campus Benefits Office.