THE CALIFORNIA STATE UNIVERSITY

# DENTAL PLAN ENROLLMENT AUTHORIZATION

CSU 692 (RV. 12/2023)

**D**

**PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE**

## SECTION A

**1. TYPE OF ACTION**

☐ **NEW** - ENROLLING IN A PLAN FOR THE FIRST TIME (*Complete Sections A, B, and D*)

☐ **CANCEL** – *(Complete Sections A, C, D)*

☐ **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D*

**2. NAME** ***(First)*** ***(Middle)*** ***(Last)***

ADDRESS *(Number and Street)*

*(City, State, and Zip)*

3. **MARITAL STATUS**
☐ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

4. **GENDER**
☐ MALE ☐ FEMALE ☐ NON-BINARY

**5. SOCIAL SECURITY NUMBER**

**6. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER**

## SECTION B

**1. NAME OF DENTAL PLAN**

**2. PROVIDER/FACILITY NUMBER** ***(If applicable) (prepaid plans only)***

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.

| ACTION CODE | LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) (First) (Middle) (Last) | DATE OF BIRTH (MM/ DD/ YY) | DEPENDENT TYPE | GENDER |
|---|---|---|---|---|
| | | | SELF | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |

**Dependent Type**:
S - Spouse; C - Child; DPC - Domestic Partner Child
DP - Domestic Partner; SC - Stepchild; PCR - Parent-child Relationship

## SECTION C

**1. PRIOR DENTAL PLAN NAME**

## SECTION D – EMPLOYEE AND EMPLOYER AUTHORIZATION

**1. CHECK APPROPRIATE BOX**

☐ I AM WAIVING ENROLLMENT IN A DENTAL PLAN *(Also applicable to enrollment in FlexCash* Dental)

☐ 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 OF 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 employee copy***)

3. DATE SIGNED

## SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

| 1. CSU DED.CODE ☐ CSU-150 | 2. DENTAL ORG. CODE | 3. PARTY CODE | 4. PAY PERIOD MONTH YEAR | 5. CSU SHARE AMOUNT $ | 6. EMPLOYEE DEDUCTION AMOUNT $ | 7. EMPLOYEE DESIGNATION | 8. BARGAINING UNIT | 9. TOTAL PREMIUM AMOUNT $ |
|---|---|---|---|---|---|---|---|---|

| COMPLETE ON CHANGES ONLY | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10. PRIOR EMPLOYER DED. CODE ☐ CSU-150 ☐ NON-CSU-351 | 11. PRIOR DENTAL ORG. CODE | PRIOR PARTY CODE | 12. PERMITTING EVENT DATE ( MM / DD /YY ) MONTH DAY YEAR | 13. PERMITTING EVENT CODE | 14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 | 15. AGENCY CODE | 16. UNIT CODE | 17. CAMPUS NAME (*IF ACTIVE EMPLOYEE*) CALPERS RETIREE? ☐ YES ☐ NO |

18 REMARKS

19. AUTHORIZED CAMPUS BENEFITS OFFICE SIGNER (PLEASE PRINT)

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 enrollment in the CSU Dental Program.*

21. TELEPHONE NUMBER *(Include Area Code)*

22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year

23. EMAIL ADDRESS

DISTRIBUTION: ORIGINAL – State Controller's Office COPY – Campus File COPY – Employee (with privacy notice)

## 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.