LACERS
LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM
Securing Your Tomorrows

Mailing Address: PO Box 512218, Los Angeles, CA 90051-0218
Visit LACERS at 202 W. First Street, Suite 500, Los Angeles, CA 90012
www.lacers.org | lacers.services@lacers.org | Mail Stop 175
(800) 779-8328 | TTY (888) 349-3996 | Fax (213) 473-7297

2020 Dental Plan Enrollment Form

1. SUBSCRIBER INFORMATION			
Last Name	**First Name, Middle Initial**	**Birth Date**	**Daytime Phone Number**
Street Address	**City**	**State**	**Zip Code**
E-mail Address:			
Status	**Retirement Effective Date**	**Gender**	**Social Security Number**
☐ Single ☐ Domestic Partnership ☐ Married ☐ Divorced ☐ Widow(er)		☐ Male ☐ Female	

2. DENTAL PLAN NAME
☐ Delta Dental PPO℠ – 17228 10001
☐ DeltaCare® USA HMO – 76992 for _____ CA 00001 or _____ parts of NV only 00003

3. LIST SELF AND ANY ELIGIBLE DEPENDENTS TO BE ENROLLED IN THE DENTAL PLAN					
Last Name, First Name, Middle Initial	**Social Security Number**	**Gender**	**Relationship**	**Birth Date (mm/dd/yy)**	**Facility # of DeltaCare® USA HMO Participating Dentist**
		☐ M ☐ F	**SELF**		
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			

FOR OFFICE USE ONLY			
INITIALS	YEARS OF SERVICE	DENTAL SUB/PART	EFFECTIVE DATE

OVER
See back for signature

4. MEMBER AUTHORIZATION

I understand this election will remain in effect as long as I remain eligible, or until I make another election during the Open Enrollment period. I hereby authorize: 1) LACERS to deduct from my retirement allowance my share of the monthly premiums as may be established from time to time in the service agreement; and 2) any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay claims under the plan selected. I want to enroll myself and those dependents listed above in the plan elected. I understand that it is my responsibility to report any change in the eligibility of my dependents and that the benefits or services of the elected plan are coordinated with those provided by any other group hospital or medical benefit or service plan. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees and providers) may be subject to binding arbitration. I understand that LACERS will select the earliest coverage date possible for me unless I notify them otherwise. I understand that double coverage is not allowed for LACERS Members already enrolled as a subscriber or dependent in another LACERS dental plan.

MEMBER'S SIGNATURE DATE SIGNED

MAIL TO: **LACERS, Attn: Health Benefits Administration**
PO Box 512218, Los Angeles, CA 90051-0218

ADA NOTICE

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.