



2023 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
<input type="checkbox"/> Single <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)		<input type="checkbox"/> Male <input type="checkbox"/> Female	

2. DENTAL PLAN NAME

- Delta Dental PPOSM – 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
		<input type="checkbox"/> M <input type="checkbox"/> F	SELF		
		<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> M <input type="checkbox"/> F			
		<input type="checkbox"/> M <input type="checkbox"/> F			

OVER

See Page 2 for Member signature

FOR OFFICE USE ONLY

INITIALS	YEARS OF SERVICE	DENTAL SUB/PART	EFFECTIVE DATE

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

SEND TO PREFERRED - EMAIL:

lacers.health@lacers.org

MAIL:

**LACERS, Attn: Health Benefits Administration
PO Box 512218**

FAX:

**Los Angeles, CA 90051-0218
(213) 473-7284**

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.