

2025 OPEN ENROLLMENT DENTAL (STD. 692) FORM EXAMPLES & COMMON ERRORS

CORRECTLY FILLED OUT DENTAL NEW FORM

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HAMAN RESOURCES DENTAL PLAN ENROLLMENT AUTHORIZATION



Print

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CORRECTLY FILLED OUT FOR ADDING OF DEPENDENT

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCE Clear Print DENTAL PLAN ENROLLMENT AUTHORIZATION STD. 692 (REV. 4/2024) PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL PAYROLL OFFICE **SECTION B SECTION A** Delta Dental PPO plus Premier Basic 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 ENFOLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED. AS ILL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED, ENTER THE ACTION CODE A (ADDI-AND/OR D COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A. B. and D) BLETS BESIDES THE NAMES OF DIALY THOSE MEMBERS TO BE ADDED OR DELETED. LIST ALL PERSONS TO BE ENROLLED IN DATE OF (Middle DEPENDENT DENTAL PLAN (Include self) GENDER BIRTH M CODE TYPE Janet Example (Middle) (Last) MM/ DOL'YY ADDRESS (Number and Street) SELF A Janet M Example 05/06/91 123 Happy St (City, State, and Zip) Jackson S Doe 06/13/90 Sacramento, CA 95816 SSN A MARITAL STATUS 3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE MARRIED MALE X FEMALE SSN DOMESTIC PARTNER NONBINARY SSN 6. SOCIAL SECURITY NUMBER 7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER 555-66-7777 SSN SECTION C (Complete for Plan changes if different than 8-1 and cancellations only) SSN 1. PRIOR DENTAL PLAN NAME Delta Dental PPO plus Premier Basic SSN SECTION D SSN 1. CHECK APPROPRIATE BOX SC - Stepchild DC - Dreatind Child PCR - Parent-child Relationship DP - Domestic Partner C - Child DPC - Domestic Partner Child I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF 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 ELIGBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA 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 Janet M. Example 9/18/2025 SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY) 2. DENTAL ORG. 3. PARTY CODE 4. PAY S. STATE SHARE 6. EMPLOYEE or 7. EMPLOYEE B. BARGAINING 1. EMPLOYER PERIOD DED CODE CODE AMOUNT COBEN DESIGNATION UNIT PREMILM DEDUCTION AMOUNT AMOUNT CSU-150 007 R MONTH YEAR X NON-CBU-351 2 12 38.12 \$ 12.7 01 50.83 25 2. PERMITTING 14 EFFECTIV COMPLETE ON CHANGES ONLY 17. AGENCY NAME OR RETIREMENT 13. PERMITTING 15. AGENCY 16. UNIT CODE EVENT DATE EVENT CODE DATE OF SYSTEM OF RETIRED CODE 10. PRIOR EMPLOYER PRIOR PRIOR DED. CODE DENTA PARTY **CAAGY** ORG. CODE CSU-150 DAY YEAR ONTH DAY YEAR CODE X NON-CSU-351 007 09 15 1 26 15 25 123 456 CALPERS RETIREE 18 REMARKS NG PERSONNEL OFFICER'S NAME (Please Print) John P Specialist Open enrollment - Adding Dependent 20. AUTHORIZED AGENCY SIGNATURE I hereby certify under penalty of pegury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification, that the employees named herein is eligible for enrollment in the State Dental Insurance Program. John P Specialist 21. TELEPHONE NUMBER (Include Area Code) 22 DATE RECEIVED IN EMPLOYING OFFICE 916-123-4567 Year Month Day transactions@agency.ca.gov 25 09 18

Distribute one copy each to Controller, Carrier, Agency, and Employee

CORRECTLY FILLED OUT FOR CHANGE OF DENTAL PLANS

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES Clear Print DENTAL PLAN ENROLLMENT AUTHORIZATION STD 492 (REV. 40004) PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNELIPAYROLL OFFICE **SECTION A** SECTION B 1. NAME OF DENTAL PLAN 1. TYPE OF ACTION Delta Dental PPO NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A. E. 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) COBRA - ENRICLEING IN COBRA CONTINUATION COVERAGE (Complete Sections A. B. and D) ELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR DI KLETE; BESIDES THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED. LIST ALL PERSONS TO BE ENROLLED IN CATECE (Midde) (Last) DEPENDENT CTO GENDER DENTAL PLAN (Include wif) BIRTH CODE TYPE Jane M Doe (Middle) East) (MIM/DD/YY) ADDRESS (Number and Street) SELF ٠ Jane M Doe 07/18/91 123 Happy St (City, State, and Zip) John B Doe 06/13/90 939-44-7777 Sacramento, CA 95816 SSN 3. CHECK F PERMANENT INTERMITTENT EMPLOYEE MARRIED SINGLE MALE X FEMALE SSN DOMESTIC PARTNER NONBINARY SSN 6 SOCIAL SECURITY NUMBER 555-55-5555 999-44-7777 SSN SECTION C (Complete for Plan changes if different than B-1 and cancellations only) SSN 1. PRIOR DENTAL PLAN NAME Premier Access SSN SECTION D SSN 1. CHECK APPROPRIATE BOX S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child DPC - Domestic Partner Child PCR - Parent-child Relationship I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Kings in employee's file) ELECT TO EMPOLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF 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 STATE OF CALIFORNIA 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 DATE SIGNED gane M. Doe 9/19/2025 SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY) 2. DENTAL ORG. 3. PARTY CODE PAY S. STATE SHARE 6. EMPLOYEE or 7. EMPLOYEE **BARGAINING** 9. TOTAL 1. EMPLOYER PERIOD DED CODE CODE AMOUNT COBEN DESIGNATION UNIT PREMIUM DEDUCTION AMOUNT AMOUNT CSU-150 R MONTH YEAR 018 X NON-CBU-361 67.73 22.5 09 90.31 12 25 12. PERMITTING COMPLETE ON CHANGES ONLY 13. PERMITTING 15 AGENCY 16. UNIT CODE 17. AGENCY NAME OR RETIREMENT EVENT DATE DATE OF SYSTEM OF RETIRED EVENT CODE CODE 10. PRIOR EMPLOYER ACTION (YY/ OD / WY) DED, CODE DENTAL PARTY SCO CODE CSU-150 YAG HTWON VEAR ROMTH DAY YEAR CODE AGENCY X NON-CSU-351 020 2 28 9 15 25 1 051 220 CALPERS RETIREE 18 REMARKS Carlos Rodriguez Open Enrollment - Changing dental plan to Delta 20 AUTHORIZED AGENCY SIGNATURE Dental PPO I hereby certify under penalty of perjury as follows: That I am the duly appoint and acting officer of the fierein named agency and that I am authorized to make this certification; that the employees named herein is eligible for enrollment in the State Dental Insurance Program. Carlos Rodrigues 21. TELEPHUNE NUMBER (MOUGE AVER CODE) 22. DATE RECEIVED IN EMPLOYING OFFICE 916-333-4444 Year Month Day SCOtransactions@sco.ca.gov 25 09 19

CORRECTLY FILLED OUT FORM OF ADDING A DEPENDENT & CHANGING PLANS

DENTAL PLAN						and the same of the same of				Clear	Р	rint		1		1
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NEW DENTAL COMMON ERRORS

EMPLOYEE (EE) HAS NOT COMPLETED THE 24-MONTH RESTRICTION PERIOD AND IS REQUIRED TO SELECT A STATE-SPONSORED PREPAID DENTAL PLAN. EE IS NOT ELIGIBLE FOR DELTA DENTAL PLAN.

DENTAL PLAN						Clear	Pri	nt		ı	
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Sacramento,	CA 95816				SSN		_			-	-
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		ganet 114 C	катрсе				9/19/2025				
SECTION E (FOR	AGENCY OR RETIR	EMENT SYSTEM U	SE ONLY)								
1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD		ATE SHARE	6. EMPLOYEE or COBEN DEDUCTION	7. EMPLOYEE DESIGNATION	B. BARG UNIT	ANNG	PRI	TAL EMIUM DUNT
CSU-150	007		MONTH YEAR			AMOUNT	R				
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ΔΩ	1 - 05/02/20	24		1	and acting office	er of the herein nam un P. Speci	ed agency and that	I am author nt in the Sta	rized to n	rake th	a certificatio
Au	. 00/02/20				- "						
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					7-444-66				Aonth	Day	Year
						s@agency	ca.gov	"	9	19	25

DENTAL ORG. CODE IS MISSING OR INVALID.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 40004)



SECTION A	SETTPE	JK USE B	ALL P	JINTP	EN, P	KINI CL	EARLT -	-	CTIC	_	EU	FORM TO P	EKSONNEL	PATRUL	OFFIC			
1. TYPE OF ACTION										F DENT	AL I	"LAN						
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(City, State, and Zip)								A	Chr	sJE	xar	mple	- 0	12/07/05	c	V	Male	-
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ARE ELIGIBLE FAN	ILY MEMBE	RS AS DEFI	MEDBYT	HE STA	TE OF	CALIFORNI	A AND ARE	NOTE	MROU	LED IN A	WO	THER STATE O	FCALIFORNIA	DENTAL PLA	N.			
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			ga	net '	16.	Examp	ue						10/10/202	5				
SECTION E (FOR A	GENCY O	R RETIR	EMENT	SYST	EM US	SE ONLY	2											
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										ADDRE		@agency			Month	Day	Ye	ear

Distribute one copy each to Controller, Carrier, Agency, and Employee

DENTAL PLAN NAME IS MISSING IN SECTION B AND SECTION E IS MISSING ALL ENTRIES.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES Print Clear DENTAL PLAN ENROLLMENT AUTHORIZATION STD. 692 (REV. 4/2024) PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE SECTION A SECTION B 1. NAME OF DENTAL PLAN 1. TYPE OF ACTION 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. R. C. and D. 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 COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D) DELETE) BESIDES THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED. LIST ALL PERSONS TO BE ENROLLED IN DATE OF 2. NAME (First) (Middle) (Last) ACTION DEPENDENT DENTAL PLAN (Include self) BIRTH GENDER CODE TYPE Janet Example (Middle) (Last) (MM/ DD/ YY ADDRESS (Number and Street) SELF 123 Happy St (City, State, and Zip) Sacramento, CA 95816 88N 3. CHECK IF PERMANENT STAL STATUS INTERMITTENT EMPLOYEE MARRIED SINGLE MALE FEMALE SSN DOMESTIC PARTNER NONBINARY 88N 6. SOCIAL SECURITY NUMBER 555-66-7777 777-88-9999 SSN SECTION C (Complete for Plan changes if different than B-1 and cancellations only) SSN 1. PRIOR DENTAL PLAN NAME SSN SECTION D SSN Dependent Type 1. CHECK APPROPRIATE BOX S-Spo DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child PCR - Parent-child Relationship DPC - Domestic Partner Child I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF 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 STATE OF CALIFORNIA 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) 2. DENTAL ORG. 3. PARTY CODE 4. PAY 5. STATE SHARE 6. EMPLOYEE or 7. EMPLOYEE 8. BARGAINING 9. TOTAL 1. EMPLOYER COBEN PREMIUM AMOUNT CODE PERIOD AMOUNT UNIT DESIGNATION DED CODE AMOUNT CSU-150 MONTH YEAR NON-CSU-351 4. EFFECTIVE 17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) COMPLETE ON CHANGES ONLY 12 PERMITTING 15. AGENCY 16. UNIT CODE DATE OF EVENT CODE CODE 10. PRIOR EMPLOYER 11 PRIOR PRIOR ACTION (MM/DD/YY) DED. CODE DENTAL PARTY ORG. CODE CSU-150 MONTH DAY YEAR ONTH DAY YEAR AGENCY NON-CSU-351 1 CALPERS RETIREE 18 REMARKS 19. SIGNING PERSONNEL OFFICER'S NAME (Please Print) 20 AUTHORIZED AGENCY SIGNATURE I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employees named herein is eligible for enrollment in the State Dental Insurance Program. HONE NUMBER (Include Area Code) 22. DATE RECEIVED IN EMPLOYING OFFICE 23 EMAIL ADDRESS Month Day Year

EMPLOYEE IS NOT ELIGIBLE FOR DELTA DENTAL PLAN DUE TO NOT MEETING THE 24-MONTH PROBATION PERIOD.

DENTAL PLAN ENROLLMENT AUTHORIZATION STD. 692 (REV. 4/2024) PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNELIPAYROLL OFFICE SECTION A SECTION B I. NAME OF DENTAL PLAN TYPE OF ACTION Delta Dental PPO plus Premier Basic NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A. B. and D) 2. PROVIDERFACILITY NUMBER (Faggitcable) (prepaid plans only) CANCEL - (Complete Sections A. C. D) CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A. E. C. and D) ELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D ELETE) BESIDES THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED. COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A. B. and D) LIST ALL PERSONS TO BE ENROLLED IN DATEOF 2. NAME. (First) CTO DEPENDENT DENTAL PLAN (Include self) CODE TYPE Example (Middle) MM/DO/Y ADDRESS (Number and Street) SELF Janet M Example A 05/06/91 123 Happy St (City, State, and Zip) Sacramento, CA 95816 SSN 3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE MARRIED X SINGLE MILE X FEMALE SSN DOMESTIC PARTNER SSN A SOCIAL SECURITY NUMBER 555-66-7777 SSN SECTION C (Complete for Plan changes if different than 8-1 and cancellations only) SSN 1. PRIOR DENTAL PLAN NAME SSN SECTION D SSN nt Type: ouse DP - Domestic Partner C - Child DPC - Domestic Partner Child F 1. CHECK APPROPRIATE BOX I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) PCR - Parent-child Relationship HELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF 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 STATE OF CALIFORNIA AND ARE NOT EMPOULED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN. I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE. 2 EMPLOYEE'S OR ANNUITANT'S SIGNATURE Janet M. Example 3. DATE SIGNED ree copy) 10/07/2025 SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY) 2. DENTAL ORG. PARTY CODE S. STATE SHARE 6. EMPLOYEE or 7. EMPLOYEE B. BARGAINING 9. TOTAL 1. EMPLOYER CODE PERIOD AMCUINT COBEN DESIGNATION UNIT PREMILIN DED CODE DEDUCTION AMOUNT CSU-150 R MONTH 007 X NON-CBU-351 1 S 38,12 \$ 12.7 80 50.83 12 25 2 PERMITTING AGENCY NAME OR RETIREMENT SYSTEM (F RETIRED) COMPLETE ON C MANGES ONLY 13. PERMITTING 15. AGENCY IS. UNIT CODE DATE OF EVENT CODE CODE PRICK EMPLOYER PRIOR PRIOR ACTION LIMM LDD (VY.) DED CODE DENTAL CA AGY ceo CODE CSU-150 MONTH DAY YEAR X AGENCY NON-CSU-351 15 09 25 03 1 456 123 CALPERS RETIREE 18 REMARKS John P. Specialist Enrolling in Dental during OE. Deleting COBEN 20. AUTHORIZED AGENCY SIGNATURE cash. John P. Specialist A01-05/02/2024 21. TELEPHONE NUMBER (INclude Area Code) 22 DATE RECEIVED IN **EMPLOYING OFFICE** 916-123-4567 Day Month Year transactions@agency.ca.gov 07 10 25

PLAN NAME IN SECTION B DOES NOT MATCH THE ORG CODE IN SECTION E.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

Clear

Print

5TD, 692 (REV, 4/2024) PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE **SECTION A** SECTION B 1. NAME OF DENTAL PLAN 1. TYPE OF ACTION DeltaCare USA 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 EMPOLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS ELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A. E. and D) LIST ALL PERSONS TO BE ENROLLED IN DATE OF 2. NAME. (First) (Middle) (Cast) DEPENDENT cro GENDER DENTAL PLAN (Include self) BIRTH Example CODE TYPE Janet M (Middle) (Lost) (MIN/ DD/ YY) ADDRESS (Number and Street) Janet M Example SELF A 05/06/91 * 123 Happy St (City, State, and Zip) Thomas K Example 1/1/12 5 BBN 222-33-4444 Sacramento, CA 95816 CHECK IF PERMANENT James R Example INTERMITTENT EMPLOYEE 3/2/13 C MARRIED Male X SINGLE MALE X FEMALE SSN 111-22-3333 DOMESTIC PARTNER NONBINARY SSN 6. SOCIAL SECURITY NUMBER 7. SPOUSE'S OR DOMESTIC PHRTNERS SOCIAL SECURITY NUMBER 555-66-7777 REN SECTION C (Complete for Plan changes if different than 8-1 and cancellations only) SSN 1. PRIOR DENTAL PLAN NAME Delta SSN SECTION D SSN Dependent Type 1. CHECK APPROPRIATE BOX 5 - Spouse DP - Domestic Partner C - Child DPC - Domestic Partner Child SC - Stepchild DC - Disabled Child PCR - Parent-child Relationship I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) FELECT TO ENROLL IN YOR CHANGE TO A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. LAUSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B. ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA 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 : 3. DATE SIGNED we copy! Janet M. Example 10/08/2025 SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY) 2. DENTAL ORG. 3. PARTY CODE PAY 5. STATE SHARE 6. EMPLOYEE or 7. EMPLOYEE **B. BARGAINING** 9. TOTAL 1. EMPLOYER PREMIUM PERIOD DESIGNATION COBEN DED CODE DEDUCTION AMOUNT AMOUNT CSU-150 R MONTH YEAR 007 NON-CSU-351 3 42.29 \$ 42.29 09 12 25 14 EFFECTIVE COMPLETE ON CHANGES ONLY 13. PERMITTING 15 AGENCY 16. UNIT CODE 17. AGENCY NAME OR RETIREMENT SYSTEM (# RETIRED) EVENT DATE DATE OF EVENT CODE CODE RIOR EMPLOYER (MM/DD/YY) ACTION DED. CODE DENTA PARTY CAAGY ORG. CODE CSU-150 MONTH DAY YEAR NONTHOAY YEAR CODE AGENCY NON-CSU-351 09 03 1 15 123 456 CALPERS RETIREE 25 NEL OFFICER'S NAME (Please Post John P. Specialist Open Enrollment. 20 AUTHORIZED AGENCY SIGNATURE hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that in the State Dental Insurance Program. John P. Specialist 21. TELEPHONE NUMBER (Include Area Code) 22. DATE RECEIVED IN EMPLOYING OFFICE 916-123-4567 Day Month Year

transactions@agency.ca.gov

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08

20 25

DEPARTMENT HUMAN RESOURCE SIGNATURE AND/OR DATE IS MISSING, PERMITTING EVENT CODE IS MISSING OR INVALID AND THE DENTAL ORG. CODE AND PARTY CODE ARE NOT IN THE CORRECT BOXES.

CODE AND PARTY CODE ARE NOT IN THE CORRECT BOXES. STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES Clear Print DENTAL PLAN ENROLLMENT AUTHORIZATION 5TD, 692 (REV, 40004) PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNELIPAYROLL OFFICE SECTION B **SECTION A** 1. TYPE OF ACTION 1. NAME OF DENTAL PLAN NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A. B. and D) 2. PROVIDERFACILITY NUMBER (If applicable) (prepaid plans only) CANCEL - /Complete Sections A. C. DI CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A. B. C. and D. WHEN CHANGING FAMILY NEMBER ENFOLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENFOLLED, AS SELECTION CODE A (ACC) AND PROPERTY TO BE ADDRESS AND DELETIES ENFORM THE RESEARCH CODE A (ACC) AND ON D DELETIE BESIDES THE MAKES OF OIL Y THOSE MEMBERS TO BE ADDRESS OF DELETIES. COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A. B. and D) LIST ALL PERSONS TO BE ENROLLED IN DATE OF 2. NAME (First) (Modele) (Last) CTION DEPENDENT DENTAL PLAN (Include self) BURTH GENDER CODE Janet Example (Middle) MM/DD/Y ADDRESS (Number and Street) SELF Janet M Example 05/06/91 123 Happy St (City, State, and Zip) Sacramento, CA 95816 SSN 3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE MALE X FEMALE X SINGLE MARRIED DOMESTIC PARTNER NONBINARY SSN 7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER 555-66-7777 SSN SECTION C (Complete for Plan changes if different than B-1 and cancellations only) SSN 1. PRIOR DENTAL PLAN NAME SSN SECTION D SSN 1. CHECK APPROPRIATE BOX se DP - Domestic Partner C - Child DPC - Domestic Partner Child SC - Stepchild DC - Disabled Child PCR - Parent-child Relationship I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF 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 STATE OF CALIFORNIA 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 3. DATE SIGNED Janet M. Example 10/08/2025 SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY) 2. DENTAL ORG. 3. PARTY CODE 4. PAY 5. STATE SHARE 6. EMPLOYEE or 7. EMPLOYEE B. BARGAINING 9. TOTAL 1. EMPLOYER CODE DESIGNATION DED CODE AMOUNT COBEN UNIT DEDUCTION AMOUNT CSU-150 MONTH YEAR R X NON-CBU-351 25 12 S 12 OF PERSONS COMPLETE ON CHANGES ONLY 13. PERMITTING 16. UNIT CODE 17. AGENCY NAME OR RETIREMENT 15. AGENCY DATE OF EVENT DATE EVENT CODE CODE SYSTEM (F RETIRED) 10. PRIOR EMPLOYER PRIOR PRIOR (MM/DD/YY) **ACTION** DED, CODE DENTAL PARTY CA AGY CODE CSU-150 DAY YEAR ONTHOAY YEAR X AGENCY CODE 15 25 NON-CSU-351 009 01 123 456 CALPERS RETIREE 26 18 REMARKS NG PERSONNEL OFFICER'S NAME (Please Print) John P. Specialist Already have this coverage. 20. AUTHORIZED AGENCY SIGNATURE I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualifies and acting officer of the herein named agency and that I am authorized to make this certification that the employees named herein is eligible for enrollment in the State Dental Insurance Program. TELEPHONE NUMBER (Include Area Code) 22 DATE RECEIVED IN EMPLOYING OFFICE -4567

transactions@agency.ca.gov

Day

08

Year

20 25

DENTAL CHANGES COMMON ERRORS

ORG CODE IS MISSING OR INVALID. ORG CODE 15 IS ADDING/DELETING OF DEPENDENT(S). THE CORRECT ORG.CODE IS 29, CHANGE OF PLAN AND ADDITION/DELETION OF DEPENDENTS.

DENTAL PLAN STD. 690 (REV. 4(2004)											Clear	P	rint			П)
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SECTION A								SE	CTION	В							
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COBRA - ENROLLIN	IS IN COBRA	CONTINUAT	ION COVE	RAGE	(Comple	ne Sections A. B. A	and D)				RS TO BE ADDED AN AMES OF CHLY THO				E A (ADE	I) AND/O	10
2. NAME (First)		(Middle)		(Les	o)			ACTION	LIST		PISONS TO BE EN		DATEOF	DEPE	NDENT	-	
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ADDRESS (Number a								A	lanet !	ME	xample		05/06/91	SF	LF		Ţ
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(City, State, and Zip)	CA OF	040					_	A	Kyle K			$\overline{}$	01/01/12	C	-	Male	١,
Sacramento,		4 MAPETAL	STATIO		_	5. GENCER	_			_	77-6666	_		-	-	-	÷
INTERMITTENT EMP		MARRI	- April	SNO	LE	ACCOUNTS.	EMALE	A			22-3333	-	03/02/13	С	~	Male	
		_							Jessic	a M	Example		44000000				П
		DOME	STIC PAR	TNER		NONBINARY		Α	SSN 6	54-	32-1111		09/15/15	C	-	Fema	1
6. SOCIAL SECURITY	NUMBER	7. SPOUSE'S O	R DOMEST	IC PART	NER'S S	OCIAL SECURITY N	WAREN				JE 1111	-				-	۳
555-66-7777									SSN					1	-		1
	1000		73K 5	1175	0.2	12/2											۳
SECTION C (Comp	slete for Plan	changes #	different	than B	1 and c	cancellations on	19)		SSN						*		ľ
1. PRIOR DENTAL PI							_							Т	·		Ę
Premier Acce	SS								SSN					\perp	Ĺ	_	L
SECTION D									SSN	_		-			*		
1. CHECK APPROPRIATE	E BOX						$\overline{}$		Depender			0 0010					_
DO NOT WISH TO	ENROLL IN	A DENTAL P	LAN (Kee	ıp in en	ployee's	s file)			3 - Spt		DP - Domestic Parti C - Domestic Parti		SC - Step PCR - Parent				-
COVER MY SHARE	E OF COST (OF ENROLLS	MENT AS	TISNO	OW OR	AS IT MAY BE IN	THE F	UTURE	I ALSO C	ERTI	FY THAT THE NA	MES OF THE PE	RISONS LIST	ED IN SE			3
I ELECT TO CANC	IEL THE DEN	ITAL PLAN S	HOWN AL	OVE.													
2. EMPLOYEE'S OR AN	NULTANTS	SIGNATURE	-0		m	o .	100	capy)				3. DATE SIGNE	D				_
			gai	net"	116.	Example						10/08/2025					
SECTION E (FOR)	AGENCY	OR RETIR	EMENT	SYST	EM U	SE ONLY)											
1. EMPLOYER DED CODE	2. DENTA CODE	L ORG.	3. PART	TV C00	Æ	4. PAY PERIOD			ATE SHAR		6. EMPLOYEE or COBEN DEDUCTION	7. EMPLOYEE DESIGNATIO		DAINING	PR	TAL EMIUM OUNT	
CSU-150	l	_	l			MONTH Y	TEAR			- 1	AMOUNT	R					
NON-CSU-351	01	8		3		12	25	s	101.	91	\$ 33.97		(01	s	135	5.8
COMPLETE ON	CHANGES	ONLY	12. PER	MITTIN	0	13. PERMITTIN		14. EF	FECTIVE.	_	15 AGENCY	16. UNIT CODE	_	INCY NA	ME OR		
10. PRIOR EMPLOYER	11. PRIOR	_	EVE	NT DAT	ne	EVENT CO			TION	- 1	CODE	10.010.000		TEM (F			
DED. CODE	DENTA ORG.	CODE											_ 0	AAG	Y		
CSU-150	CODE		MONTH	DAY	YEAR	1		MONT	HDAY YE	AR			\times	ENCY			
NON-CSU-351	016	01	9	15	25	15		1	1 2	6	123	456	0	N.PERS	RETIRE	Œ	
18 REMARKS	_	-	_	_				19.	SIGNING F	ERS	ONNEL OFFICER	S NAME (Please	Prinq				
Adding depen	ndents							Jol	n P.	Spe	ecialist						
							7		hereby of and acting	office	tency signature under penaty d r of the herein nam Specialii	perjury as folio sed agency and s		M29d to	make th	Vis cersif	catio
								- 24	**		JMBER (Include A	900 mm <u></u>		2 DATE	BECE	ED.W	_
								-	6-123-			12 COM)	ľ			OFFICE	L
							3.3		EMAIL ADO				$\overline{}$	Month	Day	Y	ear
								tra	nsacti	ons	@agency	.ca.gov		10	08	20	25

MULTIPLE PERMITTING EVENT CODES NOT ALLOWED, THE CORRECT ORG. CODE IS 29 AND DENTAL ORG. CODE NAME IS INVALID.

STATE OF CALIFORNIA - C DENTAL PLAN STD. 692 (REV. 40004)						Clear	Pr	int)
PLEAS	SE TYPE OR USE E	BALL POINT PEN, P	RINT CLEARLY -	SEND	COMPLET	ED FORM TO P	ERSONNEL	PAYROLL	OFFIC	Ε		
SECTION A				SE	CTION B							- 10
1. TYPE OF ACTION					AME OF DENT	The second secon					-	=
NEW - ENROLLING I	N A PLAN FOR THE FIRS	T TIME (Complete Section	s A, B, and D)	_		andard Plar						T
CANCEL - (Complete	Sections A. C. D)			2.P	ROVIDERFAC	LITY NUMBER (FA	pplicable) (prepar	a bave outil				
CHANGE - CHANGIN	G PLANS OR DEPENDEN	IT COVERAGE (Complete	Sections A. B. C. and Di	_								
		ION COVERAGE (Complet		MELL A	S FAMILY MEMB	AMILY MEMBER ENROL ERS TO BE ADDED AN	DIOR DELETED, ER	STER THE ACTO	ON CODE	A (ADD	ANDIOR	D
2. NAME (First)	(Middle)		a 300,000 A, D, D 0 0)		LISTALL	NAMES OF CIVILY THOS PERSONS TO BE EN		DATE OF			_	
Janet	M	Example		CODE	DE	NTAL PLAN (Include		BIRTH	DEPEN		GEND	ER
ADDRESS (Number a		Example			(First)	(Middle) (Los	0	(MM/DD/YY)				
123 Happy St.				A	Janet M 8	Example		05/06/91	SE	LF	Female	-
(City, State, and Zip)					Jessica N	/ Example		DOMESTIC .				
Sacramento, (CA 95816			Α	ssn 654	-32-1111		09/15/15	٥.	*	Female	
3. CHECK IF PERMANE INTERMITTENT EMPS		general potential	S. GENDER							V		
SELENGELLENI ENGL	MARRI	ED X SINGLE	MALE X FEMALE		SSN							_
-		_			5							
	DOME	STIC PARTNER	NONBINARY		SSN					*		*
6. SOCIAL SECURITY N	NUMBER 7. SPOUSE'S O	R DOMESTIC PARTNERS SO	DOAL SECURITY NUMBER									
555-66-7777					SSN					~		~
	2006 0 0		1 85-91 9/2									п
SECTION C (Compile	ete for Plan changes if	different than B-1 and o	rancellations only)		SSN							
1. PRIOR DENTAL PL	AN NAME										-0	П
Delta Dental F	PPO				SSN					-		
5,000,000,000												н
SECTION D					SSN		$\overline{}$			*		-
1. CHECK APPROPRIATE	BOX				Dependent T					_		
		PLAN (Keep in employee's	file)			PC - Domestic Parts		SC - Stepd CR - Parent-c				4
ARE ELIGIBLE FAM	OF COST OF ENROLLS	A DENTAL PLAN AS SHO MENT AS IT IS NOW OR A NED BY THE STATE OF HOWN ABOVE.	AS IT MAY BE IN THE F	UTURE	E. I ALSO CERT	TIFY THAT THE NAM	IES OF THE PER	RISONS LISTE	D IN SEC			3
2. EMPLOYEE'S OR AN	NUITANT'S SIGNATURE	Janet M.	on reverse of employee	сору)			3. DATE SIGNE					
		0					10/01/2025	,				
SECTION E (FOR A			SE ONLY)					_				
1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD		ATE SHARE	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATIO	8. BARG	AINING	444	TAL EMIUM OUNT	
CSU-190	Metlife		MONTH YEAR				R					
X NON-CSU-351	***************************************	2	12 25	S	25.50	\$ 0.00	1000	0	1	\$	25	.50
COMPLETE ON C	CHANGES ONLY	12 PERMITTING	13. PERMITTING		FFECTIVE	15. AGENCY	16. UNIT CODE					ENT
10. PRIOR EMPLOYER	11. PRIOR PRIOR	(MM/DD/YY)	EVENT CODE		ATE OF CTION	CODE		1000	EM (IF A		2)	
CSU-150	ORG. CODE	MONTH DAY YEAR						C	A AG	(
	CODE	MONTH DAT TEAM	2000	MUN	THOAY YEAR			N AG	ENCY			_
X NON-CSU-361	018 2	09 15 25	15/28	-1	1 26	123	456	CA	LPERS R	RETIRE	E	
18 REMARKS						SONNEL OFFICER	NAME (Please	Print)				
				Jo	hn P. Sp	ecialist						1
					I hereby certi- and acting office that the employ	ncency sichature by under penaty of her of the ferein nam ees named herein is P. Specialit	perjury as followed agency and the eligible for envolve	of I am author	tzed to n	nake th	is certific	wfor:
				21.	TELEPHONE N	NUMBER (Include Ar	ea Code)	22	DATE			_
					6-123-45						DFFICE	
				23.	EMAIL ADDRE	55		N.	fonth	Day	T House	
				tra	nsaction	is@agency	.ca.gov		10	01	200	25

FAMILY MEMBERS ARE MISSING. ALL ENROLLED FAMILY MEMBERS, INCLUDING EMPLOYEE, MUST BE LISTED IN SECTION B.

DENTAL PLAN ENROLLMENT AUTHORIZATION STD. 692 (REV. 40004) PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE SECTION A SECTION B NAME OF DENTAL IS AS 1. TYPE OF ACTION Delta Dental PPO plus Premier Enhanced NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A. E. 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. E. C. and D) 3. WHEN CHANGAYS FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS MELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED ENTER THE ACTION CODE A (ADD) AND/OR D COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A. B. and D) BLETE) BESIDES THE NAMES OF CHAY THOSE MEMBERS TO BE ADDED OR DELETED. LIST ALL PERSONS TO BE ENROLLED IN DATEOF (Last) DEPENDENT GENDER DENTAL PLAN (Include self) BIRTH CODE M Example (MASSe) MM/DD/WY (East) ADDRESS (Number and Street) SELF A Janet M Example 05/06/91 123 Happy St (City, State, and Zip) Sacramento, CA 95816 SSN 4. MARITAL STATUS 3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE MARRIED MALE X FEMALE X SINGLE SSN DOMESTIC PARTNER NONBINARY BBN 6. SOCIAL SECURITY NUMBER SPOUSE'S OR DOMESTIC PARTNERS 555-66-7777 BBN SECTION C (Complete for Plan changes if different than B-1 and cancellations only) 66N 1. PRIOR DENTAL PLAN NAME MetLife Standard Plan BBN SECTION D BBN 1. CHECK APPROPRIATE BOX SC - Stepchild DC - Disabled Child PCR - Parent-child Relationship DP - Domestic Partner C - Child DPC - Domestic Partner Child I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) FELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF 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 ELIGBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT EMPOLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN. I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE. 2 EMPLOYEE'S OR ANNULTANT'S SIGNATURE (See Privacy information on reverse of employee copy) DATE SIGNED Janet M. Example 10/07/2025 SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY) 2. DENTAL ORG. 3. PARTY CODE & EMPLOYEE OF 1. EMPLOYER PAY S. STATE SHARE 7. EMPLOYEE **B. BARGAINING** 9 TOTAL DESIGNATION CODE PERIOD PREMILM AMOUNT DED CODE COBEN UNIT DEDUCTION AMOUNT AMOUNT CSU-150 R 800 MONTH YEAR X NON-CSU-351 25 25.50 S 0.00 01 25.50 10 A SPRECTAGE COMPLETE ON CHANGES ONLY 13. PERMITTING 15. AGENCY 16. UNIT CODE AGENCY NAME OR RETIREMENT DATE OF EVENT DATE EVENT CODE CODE SYSTEM (IF RETIRED) 10. PRIOR EMPLOYER 11. PRIOR (MM/DD/YY) ACTION DED. CODE DENTA PARTY **CAAGY** CSU-150 ORG. CODE MONTH DAY YEAR KONTH DAY YEAR CODE AGENCY X NON-CSU-351 3 008 15 15 25 123 1 26 456 CALPERS RETIREE 18 REMARKS John P. Specialist Deleting Dependent from PC3 - PC2. 20 AUTHORIZED AGENCY SIGNATURE I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification, that the employees named herein is eligible for enrollment in the State Dental Insurance Program. John P. Specialist TELEPHONE NUMBER (Include Area Code) 22. DATE RECEIVED IN EMPLOYING OFFICE 916-123-4567 Month Day Year transactions@agency.ca.gov 10 07 25

SECTION E IS MISSING MULTIPLE ENTRIES.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

Clear

Print

	PE OR USE I	BALL POINT PEN, P	RINT CLEARLY			EU FORM TO P	EKSUNNEL	PATRULL	OFFICE		
SECTION A					CTION B						
1. TYPE OF ACTION					AME OF DENT						-
NEW - ENROLLING IN A PLA	N FOR THE FIRS	IT TIME (Complete Section	s A. B. and O)	_	Ita Denta	LITY NUMBER (FA	nedinable) /mana	of alless and d			-
CANCEL - (Complete Section	(A, C, D)				HUY DUTCH AL	ELLI FRUMBER (F. 8	bibucaore) (braba	io piana only)			
CHANGE - CHANGING PLAN	OR DEPENDEN	NT COVERAGE (Complete	Sections A. B. C. and D.	3. Unio	EN CHANGING FA	MALY MEMBER ENVIO	LAWREST LIST ALL	TANKS Y MEMBER	RS CURRE	VE V III	MOLLED A
COBRA - ENROLLING IN CO	IRA CONTINUAT	TION COVERAGE (Complet	te Sections A. B. and D)	HELL A	STANKLY MEMBE	ERS TO BE ACCED AN	DIOR DELETED E	NTER THE ACT	ON CODE		
2. NAME (First)	(Middle					PERSONS TO BE EN		DATEOF	DEPEND	THE	
Janet	M	Example		CODE		(Middle) (Las		BIRTH (MM/DD/YY)	TYP		GENDER
ADDRESS (Number and Stre		Lixarripio			(First)			(MANUFOLD TY)	0.51	_	
123 Happy St.	7.0			A	Janet M E	Example		05/06/91	SEL		Female *
(City, State, and Zip)	5-11-1-1-1										
Sacramento, CA 9	5816				SSN					۳	
3. CHECK IF PERMANENT	A MARITAL	prompt	S. GENCER	\vdash							- 1
INTERMITTENT EMPLOYEE	MARRI	ED SINGLE	MALE X FEMALE		SSN					Ĭ	1
	DOME	STIC PARTNER	NONBINARY								,
	-		d		SSN					_	
6. SOCIAL SECURITY NUMBER	7. SPOUSE'S C	OR DOMESTIC PARTNERS SO	OCIAL SECURITY NUMBER	1							,
555-66-7777					SSN				_		
SECTION C (Complete for	Plan changes #	different than B-1 and o	rancellations only)		SSN		_			-	
1. PRIOR DENTAL PLAN NA	ME				-					-	
DeltaCare USA					SSN					*	
SECTION D										Ţ	
				⊢	SSN				-		
1. CHECK APPROPRIATE BOX					Dependent Ty S - Spouse	DP - Domestic Plan	ther CChild	SC - Steps	ned DC	- Daw	Hed Child
I DO NOT WISH TO ENROL	LINADENTAL	PLAN (Keep in employee's	i file)	_	D	PC - Domestic Partn	er Child	PCR - Parent-	hild Relat	ionship	
I BLECT TO EMPOLL IN (C COVER MY SHARE OF OM ARE ELIGIBLE FAMLY ME I BLECT TO CANCEL THE 2 EMPLOYEE'S OR ANNUITAN Janet M.	ST OF ENROLLS MBERS AS DEFI DENTAL PLAN S T'S SIGNATURE	WENT AS IT IS NOW OR A INED BY THE STATE OF SHOWN ABOVE. [See Privacy Information	AS IT MAY BE IN THE I CALIFORNIA AND ARI	NOTE	LI ALSO CERT	IFY THAT THE NAM	MES OF THE PE	RSONS LISTE DENTAL PLAN	DINSEC		
SECTION E (FOR AGENO			SE ON! VI				10/07/2020		_	_	
				1				1			
1 EMPLOYER DED CODE CO	ITAL ORG. DE	3. PARTY CODE	PERIOD		ATE SHARE IOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATIO		AINING		EMIUM DUNT
		_	MONTH YEAR			e 0.00	R		.		
X NON-CSU-351				S	104.06			0		\$	104.0
COMPLETE ON CHANG		12 PERMITTING EVENT DATE	13. PERMITTING EVENT CODE	Di	ATE OF	15 AGENCY CODE	16. UNIT CODE		TEM (IF RE		RETIFIEMEN D)
	NTAL PARTY	(MM/00/YY)		A	CTION			C	A AGY	-	
CSU-150 CR		MONTH DAY YEAR		MONT	HOAY YEAR					-	
NON-CSU-351			•					and the same	ENCY		
									LPERS R	ETIRE	-
18 REMARKS				19.	SIGNING PER	SONNEL OFFICER	NAME (Please	PHIO			
				_							
					I hereby certifiand acting office	IGENCY SIGNATURE by under penalty of er of the herein nam ees named herein is	perjury as folio ed agency and to	hat I am autho	rized to m	alle thi	a certificati
				21	TELEPHONE N	VUMBER (Include Ar	ea Code)	22	DATE R		ED IN
					,				EMP LU	S ROPE OF	40.000
				23.	EMAIL ADDRE	55				Day	Year

INELIGIBLE DENTAL PLAN CHOSEN, EE DOES NOT QUALIFY FOR DELTA DENTAL PPO PLUS PREMIER ENHANCED (008). EE DOES QUALIFY FOR DELTA DENTAL PPO PLUS PREMIER BASIC (007) PER BAM 506.

PLEA	SE TYPE	OR USE B	ALL PO	INT PEN	PRINT CLEARLY -	SENE	COMPLET	ED FORM TO P	ERSONNEL/PA	YROLL	OFFIC	E '		
SECTION A	JE TIPE	OK OSE E	ALL PO	mer FER,	PORT CELARET	_	CTION B	ED FORM TO F	ERSONNEUTA	INOLL	OFFIC	-		
1. TYPE OF ACTION							AME OF DENT	AL PLAN						
NEW - ENROLLING	IN A PLAN FO	OR THE FIRS	TIME (Co	implete Section	s A. E. and D)	De	Ita Denta	al PPO plus	Premier E	nhan	ced			+
CANCEL - (Complete	e Sections A.	C. D)							pplicable) (prepaid p					_
CHANGE - CHANGE			t covere	OF Complete	Sactions A. B. C. and Di									
						3. 999	EN CHANGING FA	WILY MEMBER ENVIO	LMENT, LIST ALL FAM DIOR DELETED, ENTE	R THE ACT	RS CURPS ON COOK	A DACK	NACIONAL	AS D
	G IN COBRA				te Sections A, R, and D)		TO BESIDES THE P		SE MEMBERS TO BE A				_	_
2. NAME (First)		(Middle)		(Last)		CODE	DEN	NTAL PLAN (include	self)	витн	DEPEN		GEND	OR.
ADDRESS (Number of	and Street	M		Example			(First)	(Middle) (Las	d) (Mix	N/DD/YY)		_		_
123 Happy St						A	Janet M E	Example	05	906/91	SE	LF	Female	-
(City, State, and Zip)	ti.						Kyle K Ex	cample						Ħ
Sacramento,	CA 958	316				A	THE RESIDENCE OF THE PERSON NAMED IN	-77-6666	- 01	/01/12	С	"	Male	*
3. CHECK F PERMANI	ENT	4. MARITAL	STATUS		S. GENDER		James R							Ħ
INTERMITTENT EMP	LOYEE	MARRIE	io X	SINGLE	MALE X FEMALE	A	and the second second second second	-22-3333	- 03	3/02/13	C	-	Male	*
					_							П		
		DOMES	TTC PART	NER	NONBINARY		SSN							-
6. SOCIAL SECURITY	NUMBER	7. SPOUSE'S O	R DOMESTIC	CPARTNERS S	OCIAL SECURITY NUMBER						_	н		f
555-66-7777							SSN					-		-
000 00 1111										_		H		Ħ
SECTION C (Comp	lete for Plan	changes if	different ti	han 8-1 and	cancellations only)		SSN		_			~		۳
1. PRIOR DENTAL P	LAN NAME								_		_	H		Н
Delta Dental I	DESCRIPTION ASSOCIATION OF THE PERSON OF THE	lus Prei	mier P	Rasic			SSN		_			-		-
Dona Dona	1011	100	mor E	rasio			9911		_			H		H
SECTION D							SSN		_			-		-
						-	Dependent Ty	me.						_
1. CHECK APPROPRIATI					0.075		S - Spouse		ther C-Child 1	C - Stepd				á
I DO NOT WISH TO	ENROLL IN	A DENTAL P	CAN (Kee)	p in employee	s file)	_	- U	- Consist Paris	er Crisic P.Cri	- Parent	reig Pers	en en en en	-	_
					OWN ABOVE AND AUT									2
					AS IT MAY BE IN THE F CALIFORNIA AND ARE							LINON	B, ITEM 3	
I ELECT TO CANO	EL THE DEN	TAL PLAN S	HOMAN ARK	OVE										
2 EMPLOYEE'S OR AN					or many of another	10000			3. DATE SIGNED					_
Clanet	M. Es	cample	Jack Print	kly snormanor	on reverse or employee	cupyi			10/07/2025					
SECTION E (FOR			EMENT	SYSTEMI	SE ON! VI									_
	2. DENTAL		3. PART		4 PAY	le es	ATE SHARE	6. EMPLOYEE or	7. EMPLOYEE	8. BARO	AMERICA	9.70	***	
1. EMPLOYER DED CODE	CODE	Unio	a.r.Ani	· COCC	PERIOD		OUNT	COBEN	DESIGNATION	UNIT	NAME OF	PR	EMIUM	
CSU-150					•		16.00	AMOUNT				AM	OUNT	
					MONTH YEAR		1,000		R	_ •				
X NON-CSU-351	008	8		3		\$	0.00	\$ 146.18		1	2	\$	146	.18
COMPLETE ON	CHANGES C	ONLY	12. PERM		13. PERMITTING		ATE OF	15. AGENCY	16. UNIT CODE				RETIREM	ENT
10. PRIOR EMPLOYER	11. PRIOR	PRIOR		(T DATE	EVENT CODE		CTION	CODE		1000	TEM (IF I		D)	
CSU-150	ORG.	CODE	MONTH	DAY YEAR		No.	H DAY YEAR			CI CI	A AG	r		
	CODE	-				_	1 1		100		ENCY			
X NON-CSU-351	007	3	09	15 25	28	1	1 26	123	456	CA	LPERS F	RETIRE	ε	
18 REMARKS									NAME (Please Prin	0				_
OE Change						Jo	hn P. Sp	ecialist						
						20.		GENCY SIGNATURE	pecjury as follows:	That I a		le anno	and and	(Fee
						1	and acting office	or of the herein nam	ed agency and that I	are autho	rand to r	nake M	is certifica	ation
								9. Specialis	eligible for enrollmen	en me Sta	M Derta	rours	nce magn	MIT.
						-	- 67	,			DATE		E5.71	_
						21.	HELEPHONE N	IUMBER (Include A	ea Codey	22	DATE		OFFICE	
						0.4	C 422 40	107			EMP-77	71193	OL LINE	
							6-123-45 EMAIL ADDRES			-	Month .	Day		w

MANDATORY EVENT SUCH AS ADDING A SPOUSE IS NOT ALLOWED DURING OPEN ENROLLMENT. PERMITTING EVENT DATE MUST REFLECT WHEN EVENT OCCURRED. SUBESQUENT EFFECTIVE COVERAGE DATE WOULD REFLECT IN RELATION TO PERMITTING EVENT.

DI FA	SE TYPE	OR USE I	IALL DO	ONT PEN P	RINT CLEARLY -	SEND	COMPLET	ED FORM TO E	MERSONNEL	PAYROLL	OFFY		_	
SECTION A	SE TIPE	OR USE E	MEE P	poet PER, P	PORT CLEARLY.	-	CTION B	ED FORM TO F	ENSOMMED	PATROLL	OFFIC	_		
1. TYPE OF ACTION						_	AME OF DENT	AL PLAN						
NEW - ENROLLING	NAPLANE	OR THE FIRS	TIME (C	onpiete Sections	A.R. and D)	De	Ita Denta	al PPO						
CANCEL - (Complete	e Sections A.	C. D)				2.P	ROVIDERFAC	LITY NUMBER (FA	applicable) (prepa	aid plans only)				
CHANCE - CHANCE	NG PLANS O	R DEPENDEN	of covers	ACE /Complete 1	Sections A. B. C. and D)									
					Sections A. B. and D)	J. Terre	EN CHRISING FA	MALY MEMBER ENRO ERS TO BE ADDED AN	KLMENT, LIST ALL KOYON DELETED E	PAMILY MEMBE INTER THE ACT	MS CUMP YON COO	END,YE	NACUTE CAREA	D. AI
	O IN CORPO				e sections A, B, and U)	-		PERSONS TO BE EN		DATE OF	_		_	_
2. NAME (First)		(Middle)		(Last)		CODE	DES	ATAL PLAN (Include	self)	BIRTH	DEPE	PE	GEN	DER
Janet ADDRESS (Number I	and Street)	INI		Example		-	(First)	(Middle) San	0	(MM/DD/YY)	-		-	-
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(City, State, and Zip)							John B D	oe						
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