2025 OPEN ENROLLMENT DENTAL (STD. 692) FORM

EXAMPLES & COMMON ERRORS

CORRECTLY FILLED OUT DENTAL NEW FORM

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

D

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

SECTION A

1. TYPE OF ACTION

- [X] **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)*
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

2. NAME *(First)* *(Middle)* *(Last)*: Jane M Doe

ADDRESS *(Number and Street)*: 123 Happy St.

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [ ] MARRIED [X] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [X] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-55-5555

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

SECTION B

1. NAME OF DENTAL PLAN: Western Dental

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
A	Jane M Doe	07/18/91	SELF	Female
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME:

SECTION D

1. CHECK APPROPRIATE BOX

- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*
- [X] 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 *(employee copy)*: Jane M Doe

3. DATE SIGNED: 9/19/2025

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

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [X] NON-CSU-351	025	1	12	25	$ 15.77	$ 0.00	R	01	$ 15.77

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [ ] NON-CSU-351			9	15	25	03	1	1	26	051	220	SCO [X] AGENCY [ ] CALPERS RETIREE

18. REMARKS: Employee enrolling in dental for Open Enrollment

19. SIGNING PERSONNEL OFFICER'S NAME *(Please Print)*: Carlos Rodriguez

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.

Carlos Rodriguez

21. TELEPHONE NUMBER *(Include Area Code)*: 916-333-4444

23. EMAIL ADDRESS: SCOtransactions@sco.ca.gov

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 09 | Day 19 | Year 25

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

CORRECTLY FILLED OUT FOR ADDING OF DEPENDENT

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)*
- [x] **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

2. NAME *(First)* *(Middle)* *(Last)*: Janet M Example

ADDRESS *(Number and Street)*: 123 Happy St.

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [ ] MARRIED [x] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [x] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO plus Premier Basic

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
A	Janet M Example	05/06/91	SELF	Female
A	Jackson S Doe SSN	06/13/90	C	Male
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME: Delta Dental PPO plus Premier Basic

SECTION D

1. CHECK APPROPRIATE BOX

- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*
- [x] 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)*: Janet M Example

3. DATE SIGNED: 9/18/2025

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

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD (MONTH / YEAR)	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [x] NON-CSU-351	007	2	12 / 25	$ 38.12	$ 12.71	R	01	$ 50.83

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [x] NON-CSU-351	007	1	09 / 15 / 25	15	1 / 1 / 26	123	456	CA AGY [x] AGENCY [ ] CALPERS RETIREE

18 REMARKS: Open enrollment - Adding Dependent

19. SIGNING PERSONNEL OFFICER'S NAME *(Please Print)*: John P Specialist

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

21. TELEPHONE NUMBER *(Include Area Code)*: 916-123-4567

23. EMAIL ADDRESS: transactions@agency.ca.gov

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 09 / Day 18 / Year 25

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

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)*
- [x] **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

2. NAME *(First)* *(Middle)* *(Last)*: Jane M Doe

ADDRESS *(Number and Street)*: 123 Happy St.

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [x] MARRIED [ ] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [x] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-55-5555

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER: 999-44-7777

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO

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
	Jane M Doe	07/18/91	SELF	Female
	John B Doe SSN 999-44-7777	06/13/90	S	Male
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME: Premier Access

SECTION D

1. CHECK APPROPRIATE BOX

- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*
- [x] 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 *(Employee copy)*: Jane M Doe

3. DATE SIGNED: 9/19/2025

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

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [x] NON-CSU-351	018	2	12	25	$ 67.73	$ 22.58	R	09	$ 90.31

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE
[ ] CSU-150 [x] NON-CSU-351	020	2	9	15	25	28	1	1	26	051	220

17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED): [x] SCO AGENCY [ ] CALPERS RETIREE

18 REMARKS: Open Enrollment - Changing dental plan to Delta Dental PPO

19. SIGNING PERSONNEL OFFICER'S NAME *(Please Print)*: Carlos Rodriguez

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.

Carlos Rodriguez

21. TELEPHONE NUMBER (Include Area Code): 916-333-4444

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 09 Day 19 Year 25

23. EMAIL ADDRESS: SCOtransactions@sco.ca.gov

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

CORRECTLY FILLED OUT FORM OF ADDING A DEPENDENT & CHANGING PLANS

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)*
- ☐ **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

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

Jane | M | Doe

ADDRESS (Number and Street)

123 Happy St.

(City, State, and Zip)

Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE ☐

4. MARITAL STATUS: ☒ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

5. GENDER: ☐ MALE ☒ FEMALE ☐ NONBINARY

6. SOCIAL SECURITY NUMBER: 555-55-5555

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER: 999-44-7777

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO

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
	Jane M Doe	07/18/91	SELF	Female
	John B Doe SSN 999-44-7777	06/13/90	S	Male
A	Charlie S Doe SSN 444-22-5656	06/05/14	SC	Female
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME: Delta Dental PPO

SECTION D

1. CHECK APPROPRIATE BOX

- ☐ 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 *(employee copy)*: Jane M Doe

3. DATE SIGNED: 9/19/2025

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

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD (MONTH / YEAR)	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
☐ CSU-150 ☒ NON-CSU-351	018	3	12 / 25	$ 0.00	$ 44.13	S	01	$ 44.13

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
☐ CSU-150 ☒ NON-CSU-351	018	2	9 / 15 / 25	29	1 / 1 / 26	051	220	SCO ☒ AGENCY ☐ CALPERS RETIREE

18. REMARKS: Open Enrollment - Changing dental plan and Adding Dependent

19. SIGNING PERSONNEL OFFICER'S NAME *(Please Print)*: Carlos Rodriguez

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 employee named herein is eligible for enrollment in the State Dental Insurance Program.

Carlos Rodriguez

21. TELEPHONE NUMBER *(Include Area Code)*: 916-333-4444

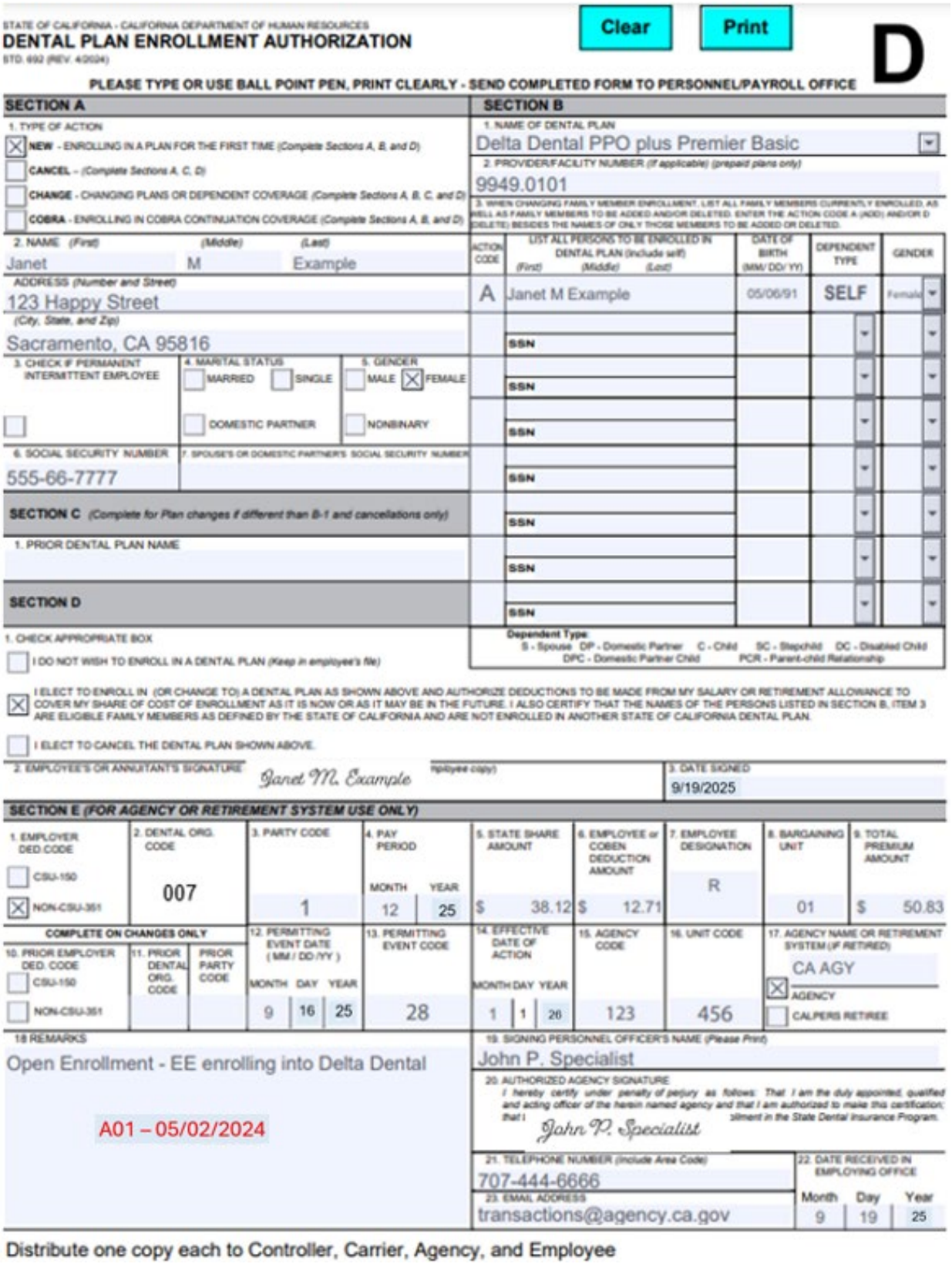
22. DATE RECEIVED IN EMPLOYING OFFICE: Month 09 | Day 19 | Year 25

23. EMAIL ADDRESS: SCOtransactions@sco.ca.gov

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

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.



STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear | Print | D

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

SECTION A

1. TYPE OF ACTION
- [X] 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)
- [ ] COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)

2. NAME (First) (Middle) (Last): Janet | M | Example

ADDRESS (Number and Street): 123 Happy Street

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [ ] MARRIED [ ] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [X] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO plus Premier Basic

2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only): 9949.0101

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
A	Janet M Example	05/06/91	SELF	Female
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME:

SECTION D

1. CHECK APPROPRIATE BOX
- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)
- [X] 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 (Employee copy): Janet M. Example

3. DATE SIGNED: 9/19/2025

SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [X] NON-CSU-351	007	1	12	25	$ 38.12	$ 12.71	R	01	$ 50.83

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [ ] NON-CSU-351			9	16	25	28	1	1	26	123	456	CA AGY [X] AGENCY [ ] CALPERS RETIREE

18. REMARKS: Open Enrollment - EE enrolling into Delta Dental

A01 – 05/02/2024

19. SIGNING PERSONNEL OFFICER'S NAME (Please Print): John P. Specialist

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 I ... ollment in the State Dental Insurance Program.
John P. Specialist

21. TELEPHONE NUMBER (Include Area Code): 707-444-6666

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 9 | Day 19 | Year 25

23. EMAIL ADDRESS: transactions@agency.ca.gov

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

DENTAL ORG. CODE IS MISSING OR INVALID.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

D

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

SECTION A

1. TYPE OF ACTION

- [X] **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)
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)

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

Janet | M | Example

ADDRESS (Number and Street)

123 Happy Street

(City, State, and Zip)

Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE [ ]

4. MARITAL STATUS: [ ] MARRIED [ ] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [X] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO plus Premier Basic

2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only): 9949.0101

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
A	Janet M Example	05/06/91	SELF	Female
A	Chris J Example SSN	12/07/05	C	Male
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)
- [X] 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 (Retain employee copy): Janet M. Example

3. DATE SIGNED: 10/10/2025

SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD (MONTH / YEAR)	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [X] NON-CSU-351	101	2	12 / 25	$ 66.56	$ 22.19	R	12	$ 88.75

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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)	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [X] NON-CSU-351			9 / 16 / 25	29	1 / 1 / 26	123	456	[X] CA AGY AGENCY [ ] CALPERS RETIREE

18. REMARKS: All supporting documents on file.

19. SIGNING PERSONNEL OFFICER'S NAME (Please Print): John P. Specialist

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 ... ollment in the State Dental Insurance Program.

John P. Specialist

21. TELEPHONE NUMBER (Include Area Code): 916-123-3456

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 10 | Day 10 | Year 25

23. EMAIL ADDRESS: transactions@agency.ca.gov

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

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)*
- ☐ **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

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

Janet M Example

ADDRESS *(Number and Street)*

123 Happy St

(City, State, and Zip)

Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE ☐

4. MARITAL STATUS ☒ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

5. GENDER ☐ MALE ☒ FEMALE ☐ NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER: 777-88-9999

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			
	SSN			

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

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ 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)*

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
☐ CSU-150 ☐ NON-CSU-351				$	$			$

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
☐ CSU-150 ☐ NON-CSU-351					1			☐ AGENCY ☐ 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.

21. TELEPHONE NUMBER *(Include Area Code)*

22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year

23. EMAIL ADDRESS

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

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)

D

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

SECTION A

1. TYPE OF ACTION
- [X] 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)
- [ ] COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)

2. NAME (First) (Middle) (Last)
Janet | M | Example

ADDRESS (Number and Street)
123 Happy St

(City, State, and Zip)
Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE
- [ ]

4. MARITAL STATUS
- [ ] MARRIED
- [X] SINGLE
- [ ] DOMESTIC PARTNER

5. GENDER
- [ ] MALE
- [X] FEMALE
- [ ] NONBINARY

6. SOCIAL SECURITY NUMBER
555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER

SECTION B

1. NAME OF DENTAL PLAN
Delta Dental PPO plus Premier Basic

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
A	Janet M Example	05/06/91	SELF	Female
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX
- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)
- [X] 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 (ee copy)
Janet M. Example

3. DATE SIGNED
10/07/2025

SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [X] NON-CSU-351	007	1	12	25	$ 38.12	$ 12.71	R	08	$ 50.83

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [ ] NON-CSU-351			09	15	25	03	1	1	26	123	456	CA AGY [X] AGENCY [ ] CALPERS RETIREE

18. REMARKS
Enrolling in Dental during OE. Deleting COBEN cash.

A01 – 05/02/2024

19. SIGNING PERSONNEL OFFICER'S NAME (Please Print)
John P. Specialist

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 th ment in the State Dental Insurance Program.
John P. Specialist

21. TELEPHONE NUMBER (Include Area Code)
916-123-4567

22. DATE RECEIVED IN EMPLOYING OFFICE
Month 10 Day 07 Year 25

23. EMAIL ADDRESS
transactions@agency.ca.gov

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

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

STD. 692 (REV. 4/2024)

Clear Print

D

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

SECTION A

1. TYPE OF ACTION

- [X] **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*)
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE (*Complete Sections A, B, and D*)

2. NAME (*First*) (*Middle*) (*Last*)
Janet M Example

ADDRESS (*Number and Street*)
123 Happy St

(*City, State, and Zip*)
Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE [ ]

4. MARITAL STATUS: [ ] MARRIED [X] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [X] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER
555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER

SECTION B

1. NAME OF DENTAL PLAN
DeltaCare USA

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
A	Janet M Example	05/06/91	SELF	Female
	Thomas K Example SSN 222-33-4444	1/1/12	S	Female
	James R Example SSN 111-22-3333	3/2/13	C	Male
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C (*Complete for Plan changes if different than B-1 and cancellations only*)

1. PRIOR DENTAL PLAN NAME
Delta

SECTION D

1. CHECK APPROPRIATE BOX

- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN (*Keep in employee's file*)
- [X] 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 (*ee copy*) Janet M. Example

3. DATE SIGNED
10/08/2025

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

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [X] NON-CSU-351	007	3	12	25	$ 42.29	$	R	09	$ 42.29

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE
[ ] CSU-150 [ ] NON-CSU-351			09	15	25	03	1	1	26	123	456

17. AGENCY NAME OR RETIREMENT SYSTEM (*IF RETIRED*)
CA AGY
[X] AGENCY [ ] CALPERS RETIREE

18. REMARKS
Open Enrollment.

19. SIGNING PERSONNEL OFFICER'S NAME (*Please Print*)
John P. Specialist

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 enrollment in the State Dental Insurance Program.
John P. Specialist

21. TELEPHONE NUMBER (*Include Area Code*)
916-123-4567

22. DATE RECEIVED IN EMPLOYING OFFICE
Month 10 Day 08 Year 20 25

23. EMAIL ADDRESS
transactions@agency.ca.gov

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

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.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

D

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

SECTION A

1. TYPE OF ACTION

- [X] **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)*
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

2. NAME *(First)* *(Middle)* *(Last)*: Janet M Example

ADDRESS *(Number and Street)*: 123 Happy St.

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [ ] MARRIED [X] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [X] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. 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
	Janet M Example	05/06/91	SELF	Female
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME:

SECTION D

1. CHECK APPROPRIATE BOX

- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*
- [X] 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 *(yee copy)*: Janet M. Example

3. DATE SIGNED: 10/08/2025

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

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [X] NON-CSU-351			12	25	$	$	R	12	$

COMPLETE ON CHANGES ONLY: 10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [ ] NON-CSU-351	009	01	09	15	25		1	1	26	123	456	CA AGY [X] AGENCY [ ] CALPERS RETIREE

18 REMARKS: Already have this coverage.

19. SIGNING PERSONNEL OFFICER'S NAME *(Please Print)*: John P. Specialist

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.

21. TELEPHONE NUMBER *(Include Area Code)*: 916-123-4567

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 10 Day 08 Year 20 25

23. EMAIL ADDRESS: transactions@agency.ca.gov

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

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.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)
- [x] CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D)
- [ ] COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)

2. NAME (First) (Middle) (Last): Janet M Example

ADDRESS (Number and Street): 123 Happy St.

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [ ] MARRIED [x] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [x] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO

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
A	Janet M Example	05/06/91	SELF	
A	Kyle K Example SSN 888-77-6666	01/01/12	C	Male
A	James R Example SSN 111-22-3333	03/02/13	C	Male
A	Jessica M Example SSN 654-32-1111	09/15/15	C	Female
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME: Premier Access

SECTION D

1. CHECK APPROPRIATE BOX
- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)
- [x] 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 copy): Janet M. Example

3. DATE SIGNED: 10/08/2025

SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [x] NON-CSU-351	018	3	12	25	$ 101.91	$ 33.97	R	01	$ 135.88

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [x] NON-CSU-351	016	01	9	15	25	15	1	1	26	123	456	[x] CA AGY AGENCY [ ] CALPERS RETIREE

18. REMARKS: Adding dependents

19. SIGNING PERSONNEL OFFICER'S NAME (Please Print): John P. Specialist

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; or enrollment in the State Dental Insurance Program.

John P. Specialist

21. TELEPHONE NUMBER (Include Area Code): 916-123-4567

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 10 Day 08 Year 20 25

23. EMAIL ADDRESS: transactions@agency.ca.gov

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

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

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)*
- [x] **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

2. NAME (First) (Middle) (Last)
Janet | M | Example

ADDRESS (Number and Street)
123 Happy St.

(City, State, and Zip)
Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE [ ]

4. MARITAL STATUS
- [ ] MARRIED
- [x] SINGLE
- [ ] DOMESTIC PARTNER

5. GENDER
- [ ] MALE
- [x] FEMALE
- [ ] NONBINARY

6. SOCIAL SECURITY NUMBER
555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER

SECTION B

1. NAME OF DENTAL PLAN
MetLife Standard 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
A	Janet M Example	05/06/91	SELF	Female
A	Jessica M Example SSN 654-32-1111	09/15/15	C	Female
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME
Delta Dental PPO

SECTION D

1. CHECK APPROPRIATE BOX
- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*
- [x] 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)*
Janet M. Example

3. DATE SIGNED
10/01/2025

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

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [x] NON-CSU-351	Metlife	2	12	25	$ 25.50	$ 0.00	R	01	$ 25.50

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [x] NON-CSU-351	018	2	09	15	25	15/28	1	1	26	123	456	CA AGY [x] AGENCY [ ] CALPERS RETIREE

18 REMARKS

19. SIGNING PERSONNEL OFFICER'S NAME *(Please Print)*
John P. Specialist

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

21. TELEPHONE NUMBER *(Include Area Code)*
916-123-4567

23. EMAIL ADDRESS
transactions@agency.ca.gov

22. DATE RECEIVED IN EMPLOYING OFFICE

Month	Day	Year
10	01	2025

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

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

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)*
- [x] **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

2. NAME *(First)* *(Middle)* *(Last)*: Janet M Example

ADDRESS *(Number and Street)*: 123 Happy St.

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [ ] MARRIED [x] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [x] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO plus Premier Enhanced

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
A	Janet M Example	05/06/91	SELF	Female
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

Dependent Type
S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child
DPC - Domestic Partner Child PCR - Parent-child Relationship

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME: MetLife Standard Plan

SECTION D

1. CHECK APPROPRIATE BOX

- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*
- [x] 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)*: Janet M. Example

3. DATE SIGNED: 10/07/2025

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

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBRA DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [x] NON-CSU-351	008	2	10	25	$ 25.50	$ 0.00	R	01	$ 25.50

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [x] NON-CSU-351	008	3	09	15	25	15	1	1	26	123	456	[x] AGENCY: CA AGY; [ ] CALPERS RETIREE

18. REMARKS: Deleting Dependent from PC3 - PC2.

19. SIGNING PERSONNEL OFFICER'S NAME *(Please Print)*: John P. Specialist

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

21. TELEPHONE NUMBER *(Include Area Code)*: 916-123-4567

23. EMAIL ADDRESS: transactions@agency.ca.gov

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 10 Day 07 Year 25

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

SECTION E IS MISSING MULTIPLE ENTRIES.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear | Print

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)*
- [x] **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*
- [ ] **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

2. NAME *(First)* *(Middle)* *(Last)*: Janet M Example

ADDRESS *(Number and Street)*: 123 Happy St.

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [ ] MARRIED [x] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [x] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO

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
A	Janet M Example	05/06/91	SELF	Female
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME: DeltaCare USA

SECTION D

1. CHECK APPROPRIATE BOX

- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*
- [x] 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)*: Janet M. Example

3. DATE SIGNED: 10/07/2025

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

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [x] NON-CSU-351					$ 104.06	$ 0.00	R	01	$ 104.06

COMPLETE ON CHANGES ONLY: 10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [x] NON-CSU-351								CA AGY [x] AGENCY [ ] 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.

21. TELEPHONE NUMBER *(Include Area Code)*

22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year

23. EMAIL ADDRESS

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

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.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)
- [x] CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D)
- [ ] COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)

2. NAME (First) (Middle) (Last): Janet M Example

ADDRESS (Number and Street): 123 Happy St.

(City, State, and Zip): Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: [ ]

4. MARITAL STATUS: [ ] MARRIED [x] SINGLE [ ] DOMESTIC PARTNER

5. GENDER: [ ] MALE [x] FEMALE [ ] NONBINARY

6. SOCIAL SECURITY NUMBER: 555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental PPO plus Premier Enhanced

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
A	Janet M Example	05/06/91	SELF	Female
A	Kyle K Example SSN 888-77-6666	01/01/12	C	Male
A	James R Example SSN 111-22-3333	03/02/13	C	Male
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

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

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME: Delta Dental PPO Plus Premier Basic

SECTION D

1. CHECK APPROPRIATE BOX
- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)

- [x] 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): Janet M. Example

3. DATE SIGNED: 10/07/2025

SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD (MONTH / YEAR)	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [x] NON-CSU-351	008	3		$ 0.00	$ 146.18	R	12	$ 146.18

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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)	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [x] NON-CSU-351	007	3	09 15 25	28	1 1 26	123	456	CA AGY [x] AGENCY [ ] CALPERS RETIREE

18 REMARKS: OE Change

19. SIGNING PERSONNEL OFFICER'S NAME (Please Print): John P. Specialist

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

21. TELEPHONE NUMBER (Include Area Code): 916-123-4567

23. EMAIL ADDRESS: transactions@agency.ca.gov

22. DATE RECEIVED IN EMPLOYING OFFICE: Month 10 Day 07 Year 25

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

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.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

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)
- [x] CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D)
- [ ] COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)

2. NAME (First) (Middle) (Last)
Janet | M | Example

ADDRESS (Number and Street)
123 Happy St.

(City, State, and Zip)
Sacramento, CA 95816

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE
- [ ]

4. MARITAL STATUS
- [x] MARRIED
- [ ] SINGLE
- [ ] DOMESTIC PARTNER

5. GENDER
- [ ] MALE
- [x] FEMALE
- [ ] NONBINARY

6. SOCIAL SECURITY NUMBER
555-66-7777

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER
999-44-7777

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME
Delta Dental PPO

SECTION D

1. CHECK APPROPRIATE BOX
- [ ] I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)
- [x] 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)
Janet M. Example

3. DATE SIGNED
10/07/2025

SECTION B

1. NAME OF DENTAL PLAN
Delta Dental PPO

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
A	Janet M Example	05/06/91	SELF	Female
A	John B Doe SSN 999-44-7777	06/13/90	S	Male
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

Dependent Type
S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child
DPC - Domestic Partner Child PCR - Parent-child Relationship

SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)

1. EMPLOYER DED CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH	4. PAY PERIOD YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
[ ] CSU-150 [x] NON-CSU-351		2	12	25	$ 67.73	$ 22.58	R	09	$ 90.31

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	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	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
[ ] CSU-150 [x] NON-CSU-351	018	1	09	15	25	29	1	1	26	123	456	CA AGY [x] AGENCY [ ] CALPERS RETIREE

18. REMARKS
Open enrollment - Adding husband to plan for 2026 due to loss of coverage.

19. SIGNING PERSONNEL OFFICER'S NAME (Please Print)
John P Specialist

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

21. TELEPHONE NUMBER (Include Area Code)
916-123-4567

23. EMAIL ADDRESS
transactions@agency.ca.gov

22. DATE RECEIVED IN EMPLOYING OFFICE
Month 10 | Day 07 | Year 25

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