



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

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. 492 (REV. 4/2024)

Clear

Print

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

SECTION A				SECTION B																																																																				
1. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input checked="" type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN Delta Dental PPO plus Premier Basic																																																																				
				2. PROVIDER/FACILITY NUMBER (if applicable) (prepaid plans only)																																																																				
2. NAME (First) (Middle) (Last) Janet M Example				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.																																																																				
ADDRESS (Number and Street) 123 Happy St. (City, State, and Zip) Sacramento, CA 95816				<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>ACTION CODE</th> <th>LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self)</th> <th>DATE OF BIRTH (MM/DD/YY)</th> <th>DEPENDENT TYPE</th> <th>GENDER</th> </tr> <tr> <th>(First)</th> <th>(Middle)</th> <th>(Last)</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>A</td> <td>Janet M Example</td> <td>05/06/91</td> <td>SELF</td> <td>Female</td> </tr> <tr> <td>A</td> <td>Jackson S Doe</td> <td>06/13/90</td> <td>C</td> <td>Male</td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self)	DATE OF BIRTH (MM/DD/YY)	DEPENDENT TYPE	GENDER	(First)	(Middle)	(Last)			A	Janet M Example	05/06/91	SELF	Female	A	Jackson S Doe	06/13/90	C	Male		SSN										SSN										SSN										SSN										SSN			
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				5. STATE SHARE AMOUNT \$ 38.12		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 12.71																																																																		
				7. EMPLOYEE DESIGNATION R		8. BARGAINING UNIT 01																																																																		
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				14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26		15. AGENCY CODE 123																																																																		
				16. UNIT CODE 456		17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE																																																																		
18. REMARKS Open enrollment - Adding Dependent				19. SIGNING PERSONNEL OFFICER'S NAME (Please Print) John P Specialist																																																																				
				20. AUTHORIZED AGENCY SIGNATURE <i>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.</i> John P Specialist																																																																				
				21. TELEPHONE NUMBER (include Area Code) 916-123-4567		22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year 09 18 25																																																																		
				23. EMAIL ADDRESS transactions@agency.ca.gov																																																																				

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

CORRECTLY FILLED OUT FOR CHANGE OF DENTAL PLANS

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8. GENDER Female				9. GENDER Male			
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						DEPENDENT TYPE SELF S SC	
						GENDER Female Male Female	
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				5. STATE SHARE AMOUNT \$ 0.00		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 44.13	
				7. EMPLOYEE DESIGNATION S		8. BARGAINING UNIT 01	
				9. TOTAL PREMIUM AMOUNT \$ 44.13			
COMPLETE ON CHANGES ONLY		10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE 018		12. PRIOR PARTY CODE 2	
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				16. AGENCY CODE 051		17. UNIT CODE 220	
				18. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) SCO <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> 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 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 Day Year 09 19 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. 492 (REV. 4/2024)				Clear	Print	D																																													
PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE																																																			
SECTION A				SECTION B																																															
1. TYPE OF ACTION <input checked="" type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN Delta Dental PPO plus Premier Basic																																															
				2. PROVIDER/FACILITY NUMBER (if applicable) (prepaid plans only) 9949.0101																																															
2. NAME (First) (Middle) (Last) Janet M Example				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.																																															
ADDRESS (Number and Street) 123 Happy Street (City, State, and Zip) Sacramento, CA 95816				<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>ACTION CODE</th> <th>LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self)</th> <th>DATE OF BIRTH (MM/DD/YY)</th> <th>DEPENDENT TYPE</th> <th>GENDER</th> </tr> </thead> <tbody> <tr> <td>A</td> <td>Janet M Example</td> <td>05/06/91</td> <td>SELF</td> <td>Female</td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SSN</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self)	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			
ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self)	DATE OF BIRTH (MM/DD/YY)	DEPENDENT TYPE	GENDER																																															
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	SSN																																																		
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	SSN																																																		
3. CHECK IF PERMANENT <input type="checkbox"/> INTERMITTENT EMPLOYEE <input type="checkbox"/>				4. MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> NONBINARY																																															
6. SOCIAL SECURITY NUMBER 555-66-7777				7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER SSN																																															
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)																																																			
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SECTION D																																																			
1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				3. DATE SIGNED 9/19/2025																																															
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE <i>Janet M. Example</i>				3. DATE SIGNED 9/19/2025																																															
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)																																																			
1. EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351	2. DENTAL ORG. CODE 007	3. PARTY CODE 1	4. PAY PERIOD MONTH YEAR 12 25	5. STATE SHARE AMOUNT \$ 38.12	6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 12.71	7. EMPLOYEE DESIGNATION R	8. BARGAINING UNIT 01	9. TOTAL PREMIUM AMOUNT \$ 50.83																																											
10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE 007	12. PERMITTING EVENT DATE (MM/DD/YY) MONTH DAY YEAR 9 16 25	13. PERMITTING EVENT CODE 28	14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26	15. AGENCY CODE 123	16. UNIT CODE 456	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) <input checked="" type="checkbox"/> CA AGY <input type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE																																											
18. REMARKS Open Enrollment - EE enrolling into Delta Dental <div style="border: 1px solid red; padding: 5px; color: red; display: inline-block;">A01 - 05/02/2024</div>				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 <i>John P. Specialist</i>				21. TELEPHONE NUMBER (include Area Code) 707-444-6666																																															
22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year 9 19 25				23. EMAIL ADDRESS transactions@agency.ca.gov																																															

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

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES
DENTAL PLAN ENROLLMENT AUTHORIZATION
STD. 692 (REV. 4/2004)

Print

D

SECTION A				SECTION B			
1. TYPE OF ACTION <input checked="" type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN <div style="border: 1px solid black; padding: 2px;">Delta Dental PPO plus Premier Basic</div>			
				2. PROVIDER/FACILITY NUMBER (if applicable) (prepaid plans only) <div style="border: 1px solid black; padding: 2px;">9949.0101</div>			
2. NAME (First) (Middle) (Last) <div style="display: flex; justify-content: space-between;"> <div>Janet</div> <div>M</div> <div>Example</div> </div>				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.		DATE OF BIRTH (MM/DD/YY) <div style="display: flex; justify-content: space-between;"> <div>05/06/91</div> <div>12/07/05</div> </div>	
ADDRESS (Number and Street) <div style="border: 1px solid black; padding: 2px;">123 Happy Street</div>				LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (include self) <div style="display: flex; justify-content: space-between;"> <div>Janet M Example</div> <div>Chris J Example</div> </div>		DEPENDENT TYPE <div style="display: flex; justify-content: space-between;"> <div>SELF</div> <div>C</div> </div>	
(City, State, and Zip) <div style="border: 1px solid black; padding: 2px;">Sacramento, CA 95816</div>				SSN <div style="display: flex; justify-content: space-between;"> <div></div> <div></div> </div>		GENDER <div style="display: flex; justify-content: space-between;"> <div>Female</div> <div>Male</div> </div>	
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>		4. MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE		5. GENDER <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> NONBINARY			
6. SOCIAL SECURITY NUMBER <div style="border: 1px solid black; padding: 2px;">555-66-7777</div>		7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER <div style="border: 1px solid black; padding: 2px;"></div>					
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)							
1. PRIOR DENTAL PLAN NAME <div style="border: 1px solid black; padding: 2px;"></div>							
SECTION D							
1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				Dependent Type S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child DPC - Domestic Partner Child PCR - Parent-child Relationship			
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE <i>Janet M. Example</i> <small>(see copy)</small>				3. DATE SIGNED <div style="border: 1px solid black; padding: 2px;">10/10/2025</div>			
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)							
1. EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		2. DENTAL ORG. CODE <div style="border: 2px solid red; padding: 5px; display: inline-block;">101</div>		3. PARTY CODE <div style="border: 1px solid black; padding: 2px; display: inline-block;">2</div>		4. PAY PERIOD MONTH YEAR <div style="display: flex; justify-content: space-around;"> <div>12</div> <div>25</div> </div>	
				5. STATE SHARE AMOUNT \$ 66.56		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 22.19	
						7. EMPLOYEE DESIGNATION <div style="border: 1px solid black; padding: 2px; display: inline-block;">R</div>	
						8. BARGAINING UNIT <div style="border: 1px solid black; padding: 2px; display: inline-block;">12</div>	
						9. TOTAL PREMIUM AMOUNT \$ 88.75	
COMPLETE ON CHANGES ONLY				12. PERMITTING EVENT DATE (MM/DD/YY) MONTH DAY YEAR <div style="display: flex; justify-content: space-around;"> <div>9</div> <div>16</div> <div>25</div> </div>		13. PERMITTING EVENT CODE <div style="border: 1px solid black; padding: 2px; display: inline-block;">29</div>	
10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE <div style="border: 1px solid black; padding: 2px;"></div>		14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR <div style="display: flex; justify-content: space-around;"> <div>1</div> <div>1</div> <div>20</div> </div>		15. AGENCY CODE <div style="border: 1px solid black; padding: 2px; display: inline-block;">123</div>	
						16. UNIT CODE <div style="border: 1px solid black; padding: 2px; display: inline-block;">456</div>	
						17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) <div style="border: 1px solid black; padding: 2px;">CA AGY</div> <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE	
18. REMARKS <div style="border: 1px solid black; padding: 5px; min-height: 40px;">All supporting documents on file.</div>				19. SIGNING PERSONNEL OFFICER'S NAME (Please Print) <div style="border: 1px solid black; padding: 2px;">John P. Specialist</div>			
				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: <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-top: 10px;"><i>John P. Specialist</i></div>			
				21. TELEPHONE NUMBER (include Area Code) <div style="border: 1px solid black; padding: 2px;">916-123-3456</div>		22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year <div style="display: flex; justify-content: space-around;"> <div>10</div> <div>10</div> <div>25</div> </div>	
				23. EMAIL ADDRESS <div style="border: 1px solid black; padding: 2px;">transactions@agency.ca.gov</div>			

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				SECTION B					
1. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN					
2. NAME (First) (Middle) (Last) Janet M Example				2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only)					
ADDRESS (Number and Street) 123 Happy St (City, State, and Zip) Sacramento, CA 95816				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.					
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>		4. MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER		5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> NONBINARY		ACTION CODE			
6. SOCIAL SECURITY NUMBER 555-66-7777		7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER 777-88-9999		LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) (First) (Middle) (Last)		DATE OF BIRTH (MM/DD/YY)	DEPENDENT TYPE	GENDER	
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)				SSN				SELF	
1. PRIOR DENTAL PLAN NAME				SSN					
SECTION D				SSN					
1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				Dependent Type: S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child DPC - Domestic Partner Child PCR - Parent-child Relationship					
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 <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351	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 \$	
COMPLETE ON CHANGES ONLY			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) <input type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE	
10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351	11. PRIOR DENTAL ORG. CODE	11. PRIOR PARTY CODE			1				
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)

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

D

SECTION A				SECTION B													
1. TYPE OF ACTION <input checked="" type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN Delta Dental PPO plus Premier Basic													
2. NAME (First Middle Last) Janet M Example				2. PROVIDER/FACILITY NUMBER (if applicable) (prepaid plans only)													
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>				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.													
4. MARITAL STATUS <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> NONBINARY				5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE													
6. SOCIAL SECURITY NUMBER 555-66-7777				7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER													
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)				SECTION D													
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2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE Janet M. Example				3. DATE SIGNED 10/07/2025													
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)																	
1. EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		2. DENTAL ORG. CODE 007		3. PARTY CODE 1		4. PAY PERIOD MONTH YEAR 12 25		5. STATE SHARE AMOUNT \$ 38.12		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 12.71		7. EMPLOYEE DESIGNATION R		8. BARGAINING UNIT 08		9. TOTAL PREMIUM AMOUNT \$ 50.83	
10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE		12. PERMITTING EVENT DATE (MM / DD / YY) MONTH DAY YEAR 09 15 25		13. PERMITTING EVENT CODE 03		14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26		15. AGENCY CODE 123		16. UNIT CODE 456		17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> 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 the [] named in the State Dental Insurance Program. John P. Specialist 21. TELEPHONE NUMBER (Include Area Code) 916-123-4567 22. EMAIL ADDRESS transactions@agency.ca.gov 22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year 10 07 25								

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				SECTION B			
1. TYPE OF ACTION <input checked="" type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN DeltaCare USA			
2. NAME (First) (Middle) (Last) Janet M Example ADDRESS (Number and Street) 123 Happy St (City, State, and Zip) Sacramento, CA 95816				2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only)			
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/> PERMANENT <input type="checkbox"/> INTERMITTENT				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.			
4. MARITAL STATUS <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE		5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE		LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) (First) (Middle) (Last)		DATE OF BIRTH (MM/DD/YY)	
<input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> NONBINARY				Janet M Example 05/06/91 DEPENDENT TYPE SELF		GENDER Female	
6. SOCIAL SECURITY NUMBER 555-66-7777		7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER		Thomas K Example 1/1/12 S		Female	
				James R Example 3/2/13 C		Male	
				SSN			
				SSN			
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 <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				Dependent Type: S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child DPC - Domestic Partner Child PCR - Parent-child Relationship			
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE Janet M. Example				3. DATE SIGNED 10/08/2025			
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)							
1. EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		2. DENTAL ORG. CODE 007		3. PARTY CODE 3		4. PAY PERIOD MONTH YEAR 12 25	
				5. STATE SHARE AMOUNT \$ 42.29		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$	
				7. EMPLOYEE DESIGNATION R		8. BARGAINING UNIT 09	
				9. TOTAL PREMIUM AMOUNT \$ 42.29			
10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351		12. PERMITTING EVENT DATE (MM/DD/YY) MONTH DAY YEAR 09 15 25		13. PERMITTING EVENT CODE 03	
				14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26		15. AGENCY CODE 123	
				16. UNIT CODE 456		17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> 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; the John P. Specialist			
				21. TELEPHONE NUMBER (include Area Code) 916-123-4567			
				22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year 10 08 2025			
				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

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D

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

SECTION A				SECTION B			
1. TYPE OF ACTION <input checked="" type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN			
2. NAME (First) (Middle) (Last) Janet M Example				2. PROVIDER/FACILITY NUMBER (if applicable) (prepaid plans only)			
ADDRESS (Number and Street) 123 Happy St. (City, State, and Zip) Sacramento, CA 95816				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.			
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>		4. MARITAL STATUS <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> NONBINARY		5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE		LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) (First) (Middle) (Last)	
6. SOCIAL SECURITY NUMBER 555-66-7777		7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER		DATE OF BIRTH (MM/DD/YY) 05/05/91		DEPENDENT TYPE SELF	
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)				GENDER Female			
1. PRIOR DENTAL PLAN NAME				SSN			
SECTION D				SSN			
1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				SSN			
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE Janet M. Example (see copy)				3. DATE SIGNED 10/08/2025			
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)							
1. EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		2. DENTAL ORG. CODE ●		3. PARTY CODE ●		4. PAY PERIOD MONTH YEAR 12 25	
5. STATE SHARE AMOUNT \$		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$		7. EMPLOYEE DESIGNATION R		8. BARGAINING UNIT 12	
9. TOTAL PREMIUM AMOUNT \$		10. PRIOR EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE 009		12. PRIOR PARTY CODE 01	
13. PERMITTING EVENT DATE (MM/DD/YY) MONTH DAY YEAR 09 15 25		14. PERMITTING EVENT CODE ●		15. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26		16. AGENCY CODE 123	
17. UNIT CODE 456		18. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE		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 Day Year 10 08 2025			
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										Clear		Print		D				
DENTAL PLAN ENROLLMENT AUTHORIZATION																		
STD. 662 (REV. 4/01/04)																		
PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE																		
SECTION A					SECTION B													
1. TYPE OF ACTION					1. NAME OF DENTAL PLAN													
<input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input checked="" type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)					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.													
2. NAME (First) (Middle) (Last)					ACTION CODE		LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self)		DATE OF BIRTH (MM/DD/YY)		DEPENDENT TYPE		GENDER					
Janet M Example					A		Janet M Example		05/06/91		SELF							
ADDRESS (Number and Street)					A		Kyle K Example		01/01/12		C		Male					
123 Happy St.							SSN 888-77-6666											
(City, State, and Zip)							James R Example		03/02/13		C		Male					
Sacramento, CA 95816							SSN 111-22-3333											
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE					4. MARITAL STATUS		5. GENDER											
<input type="checkbox"/>					<input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE		<input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE											
<input type="checkbox"/>					<input type="checkbox"/> DOMESTIC PARTNER		<input type="checkbox"/> NONBINARY											
6. SOCIAL SECURITY NUMBER					7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER													
555-66-7777																		
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					Dependent Type													
<input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)					S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child DPC - Domestic Partner Child PCR - Parent-child Relationship													
<input checked="" type="checkbox"/> 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.																		
<input type="checkbox"/> 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)																		
1. EMPLOYER DED CODE		2. DENTAL ORG. CODE		3. PARTY CODE		4. PAY PERIOD		5. STATE SHARE AMOUNT		6. EMPLOYEE or COBEN DEDUCTION AMOUNT		7. EMPLOYEE DESIGNATION		8. BARGAINING UNIT		9. TOTAL PREMIUM AMOUNT		
<input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		018		3		MONTH YEAR 12 25		\$ 101.91		\$ 33.97		R		01		\$ 135.88		
COMPLETE ON CHANGES ONLY																		
10. PRIOR EMPLOYER DED. CODE		11. PRIOR DENTAL ORG. CODE		12. PERMITTING EVENT DATE (MM/DD/YY)		13. PERMITTING EVENT CODE		14. EFFECTIVE DATE OF ACTION		15. AGENCY CODE		16. UNIT CODE		17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)				
<input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		016		01		9 15 25		15		1 1 26		123		456		<input checked="" type="checkbox"/> CA AGY <input type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE		
18. REMARKS															19. SIGNING PERSONNEL OFFICER'S NAME (Please Print)			
Adding dependents															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.			
															21. TELEPHONE NUMBER (include Area Code)			
															916-123-4567			
															22. DATE RECEIVED IN EMPLOYING OFFICE			
															Month Day Year			
															10 08 2025			
															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)

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D

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

SECTION A				SECTION B													
1. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input checked="" type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN MetLife Standard Plan													
2. NAME (First) (Middle) (Last) Janet M Example				2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only)													
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>				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.													
4. MARITAL STATUS <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> NONBINARY				5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE													
6. SOCIAL SECURITY NUMBER 555-66-7777				7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER													
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)				8. DATE OF BIRTH (MM/DD/YY)													
1. PRIOR DENTAL PLAN NAME Delta Dental PPO				9. DEPENDENT TYPE													
SECTION D				10. GENDER													
1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				11. ACTION CODE A													
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE (See Privacy information on reverse of employee copy) Janet M. Example				12. DATE SIGNED 10/01/2025													
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)				13. DEPENDENT TYPE S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child DPC - Domestic Partner Child PCR - Parent-child Relationship													
1. EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		2. DENTAL ORG. CODE MetLife		3. PARTY CODE 2		4. PAY PERIOD MONTH YEAR 12 25		5. STATE SHARE AMOUNT \$ 25.50		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 0.00		7. EMPLOYEE DESIGNATION R		8. BARGAINING UNIT 01		9. TOTAL PREMIUM AMOUNT \$ 25.50	
10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE 018		12. PRIOR PARTY CODE 2		13. PERMITTING EVENT DATE (MM/DD/YY) MONTH DAY YEAR 09 15 25		14. PERMITTING EVENT CODE 15/28		15. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26		16. AGENCY CODE 123		17. UNIT CODE 456		18. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE	
19. 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							
22. EMAIL ADDRESS transactions@agency.ca.gov										23. 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)

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D

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

SECTION A				SECTION B					
1. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input checked="" type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN Delta Dental PPO plus Premier Enhanced					
2. NAME (First) (Middle) (Last) Janet M Example				2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only)					
ADDRESS (Number and Street) 123 Happy St. (City, State, and Zip) Sacramento, CA 95816				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.					
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/> PERMANENT <input type="checkbox"/> INTERMITTENT				ACTION CODE					
4. MARITAL STATUS <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER				LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) (First) (Middle) (Last)					
5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> NONBINARY				DATE OF BIRTH (MM/DD/YY)					
6. SOCIAL SECURITY NUMBER 555-66-7777				DEPENDENT TYPE					
7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER				GENDER					
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)				A Janet M Example 05/06/91 SELF Female					
1. PRIOR DENTAL PLAN NAME MetLife Standard Plan				SSN					
SECTION D				SSN					
1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employer's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				Dependent Type S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child DPC - Domestic Partner Child PCR - Parent-child Relationship					
2. EMPLOYEE'S OR ANNULANT'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 <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351	2. DENTAL ORG. CODE 008	3. PARTY CODE 2	4. PAY PERIOD MONTH YEAR 10 25	5. STATE SHARE AMOUNT \$ 25.50	6. EMPLOYEE OR COBEN DEDUCTION AMOUNT \$ 0.00	7. EMPLOYEE DESIGNATION R	8. BARGAINING UNIT 01	9. TOTAL PREMIUM AMOUNT \$ 25.50	
COMPLETE ON CHANGES ONLY				12. PERMITTING EVENT DATE (MM/DD/YY) MONTH DAY YEAR 09 15 25	13. PERMITTING EVENT CODE 15	14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26	15. AGENCY CODE 123	16. UNIT CODE 456	
10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351	11. PRIOR DENTAL ORG. CODE 008	11. PRIOR PARTY CODE 3	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> 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 employee named herein is eligible for 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 Day Year 10 07 25	
				23. EMAIL ADDRESS transactions@agency.ca.gov					

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)

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

SECTION A				SECTION B				
1. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input checked="" type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN Delta Dental PPO				
2. NAME (First) (Middle) (Last) Janet M Example ADDRESS (Number and Street) 123 Happy St. (City, State, and Zip) Sacramento, CA 95816				2. PROVIDER/FACILITY NUMBER (if applicable) (prepaid plans only)				
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>				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.				
4. MARITAL STATUS <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE		5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE		LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) (First) (Middle) (Last)		DATE OF BIRTH (MM/ DD/ YY)	DEPENDENT TYPE	GENDER
<input type="checkbox"/> DOMESTIC PARTNER		<input type="checkbox"/> NONBINARY		Janet M Example		05/06/91	SELF	Female
6. SOCIAL SECURITY NUMBER 555-66-7777		7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER		SSN				
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)				SSN				
1. PRIOR DENTAL PLAN NAME DeltaCare USA				SSN				
SECTION D				SSN				
1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				Dependent Type: S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child DPC - Domestic Partner Child PCR - Parent-child Relationship				
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 <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351	2. DENTAL ORG. CODE	3. PARTY CODE ●	4. PAY PERIOD MONTH YEAR ●	5. STATE SHARE AMOUNT \$ 104.06	6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 0.00	7. EMPLOYEE DESIGNATION R	8. BARGAINING UNIT 01	9. TOTAL PREMIUM AMOUNT \$ 104.06
COMPLETE ON CHANGES ONLY			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) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE
10. PRIOR EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351	11. PRIOR DENTAL ORG. CODE ●	PRIOR PARTY CODE ●	MONTH DAY YEAR ●	MONTH DAY YEAR ●	MONTH DAY YEAR ●	MONTH DAY YEAR ●	MONTH DAY YEAR ●	MONTH DAY YEAR ●
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				SECTION B			
1. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input checked="" type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN Delta Dental PPO plus Premier Enhanced			
2. NAME (First) (Middle) (Last) Janet M Example				2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only)			
ADDRESS (Number and Street) 123 Happy St. (City, State, and Zip) Sacramento, CA 95816				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.			
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>		4. MARITAL STATUS <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> NONBINARY		5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE		6. SOCIAL SECURITY NUMBER 555-66-7777	
7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER				8. DATE OF BIRTH (MM/DD/YY)			
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)				SECTION D			
1. PRIOR DENTAL PLAN NAME Delta Dental PPO Plus Premier Basic				2. DATE SIGNED 10/07/2025			
1. CHECK APPROPRIATE BOX <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> 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			
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)				3. DATE SIGNED 10/07/2025			
1. EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		2. DENTAL ORG. CODE 008		3. PARTY CODE 3		4. PAY PERIOD MONTH YEAR	
5. STATE SHARE AMOUNT \$ 0.00		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 146.18		7. EMPLOYEE DESIGNATION R		8. BARGAINING UNIT 12	
9. TOTAL PREMIUM AMOUNT \$ 146.18		10. PRIOR EMPLOYER DED. CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE 007		12. PRIOR PARTY CODE 3	
13. PERMITTING EVENT DATE (MM/DD/YY) MONTH DAY YEAR 09 15 25		14. PERMITTING EVENT CODE 28		15. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26		16. AGENCY CODE 123	
17. UNIT CODE 456		18. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> CALPERS RETIREE		19. SIGNING PERSONNEL OFFICER'S NAME (Please Print) John P. Specialist		20. AUTHORIZED EMPLOYEE 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		22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year 10 07 25		23. EMAIL ADDRESS transactions@agency.ca.gov			

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. SUBSEQUENT EFFECTIVE COVERAGE DATE WOULD REFLECT IN RELATION TO PERMITTING EVENT.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES		Clear		Print		D											
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. TYPE OF ACTION <input type="checkbox"/> NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D) <input type="checkbox"/> CANCEL - (Complete Sections A, C, D) <input checked="" type="checkbox"/> CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D) <input type="checkbox"/> COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)				1. NAME OF DENTAL PLAN Delta Dental PPO													
2. NAME (First) (Middle) (Last) Janet M Example				2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only)													
ADDRESS (Number and Street) 123 Happy St. (City, State, and Zip) Sacramento, CA 95816				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.													
3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE <input type="checkbox"/>				4. MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE		5. GENDER <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE											
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 <input type="checkbox"/> I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.				2. DATE SIGNED 10/07/2025													
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE (See Privacy information on reverse of employee copy) Janet M. Example																	
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)																	
1. EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		2. DENTAL ORG. CODE		3. PARTY CODE 2		4. PAY PERIOD MONTH YEAR 12 25		5. STATE SHARE AMOUNT \$ 67.73		6. EMPLOYEE or COBEN DEDUCTION AMOUNT \$ 22.58		7. EMPLOYEE DESIGNATION R		8. BARGAINING UNIT 09		9. TOTAL PREMIUM AMOUNT \$ 90.31	
10. PRIOR EMPLOYER DED CODE <input type="checkbox"/> CSU-150 <input checked="" type="checkbox"/> NON-CSU-351		11. PRIOR DENTAL ORG. CODE 018		12. PERMITTING EVENT DATE (MM/DD/YY) MONTH DAY YEAR 09 15 25		13. PERMITTING EVENT CODE 29		14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR 1 1 26		15. AGENCY CODE 123		16. UNIT CODE 456		17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) CA AGY <input checked="" type="checkbox"/> AGENCY <input type="checkbox"/> 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				22. DATE RECEIVED IN EMPLOYING OFFICE Month Day Year 10 07 25					
								23. EMAIL ADDRESS transactions@agency.ca.gov									

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