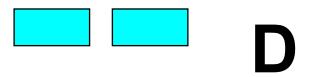
STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES **DENTAL PLAN ENROLLMENT AUTHORIZATION**



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

SECTION A	ION A SECTION B						
1. TYPE OF ACTION	1. NAME OF DEN	TAL PLAN					
NEW - ENROLLING IN A PLAN FOR THE FIRST TIME (Complete Sections A, B, and D)							
CANCEL – (Complete Sections A, C, D)	2. PROVIDER/FAC	2. PROVIDER/FACILITY NUMBER (If applicable) (prepaid plans only)					
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)	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)		PERSONS TO BE ENF NTAL PLAN (Include		DATE OF BIRTH	DEPENDENT	GENDER	
	CODE (First)	(Middle) (Las		MM/ DD/ YY)	TYPE	GENDEN	
ADDRESS (Number and Street)							
(City, State, and Zip)							
	SSN						
3. CHECK IF PERMANENT 4. MARITAL STATUS 5. GENDER							
	SSN						
	SSN						
6. SOCIAL SECURITY NUMBER 7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER	۲						
	SSN						
SECTION C (Complete for Plan changes if different than B-1 and cancellations only)							
1. PRIOR DENTAL PLAN NAME	SSN						
I. FRIOR DENTAL FLAIN NAME	SSN						
	331						
SECTION D	SSN						
1. CHECK APPROPRIATE BOX		Dependent Type:					
I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)	S - Spouse C - Child DPC - Domestic Partner Child DP - Domestic Partner SC - Stepchild PCR - Parent-child Relationship						
I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUT COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE	FUTURE. I ALSO CER	TIFY THAT THE NAM	IES OF THE PERS	SONS LISTED I			
ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARI	E NOT ENROLLED IN	ANOTHER STATE O	F CALIFORNIA DE	ENTAL PLAN.			
I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.							
2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE (See Privacy Information on reverse of employed	copy) 3. DATE SIGNED						
SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)							
1. EMPLOYER 2. DENTAL ORG. 3. PARTY CODE 4. PAY DED.CODE CODE PERIOD	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN	7. EMPLOYEE DESIGNATION	8. BARGAII UNIT	PRE	MUM	
CSU-150		DEDUCTION AMOUNT			AMO	DUNT	
MONTH YEAR	¢	¢					
NON-CSU-351	\$	\$			\$		
COMPLETE ON CHANGES ONLY 12. PERMITTING 13. PERMITTING 10. PRIOR EMPLOYER 11. PRIOR PRIOR CMM (DD (YY)) EVENT CODE	14. EFFECTIVE DATE OF	15. AGENCY CODE	16. UNIT CODE		Y NAME OR F M (<i>IF RETIREL</i>		
DED. CODE DENTAL PARTY	ACTION						
CSU-150 ORG. CODE MONTH DAY YEAR	MONTH DAY YEAR				ICY		
NON-CSU-351					ERS RETIRE	Ξ	
18 REMARKS	19. SIGNING PER	SONNEL OFFICER'S	L S NAME (<i>Please Pr</i>	rint)			
		AGENCY SIGNATUR		s: That I am ti	he duly appoir	nted, qualified	
	and acting offic	cer of the herein nam yees named herein is	ed agency and that	t I am authorize	ed to make thi	s certification;	

21. TELEPHONE NUMBER (Include Area Code)	22. DATE RECEIVED IN EMPLOYING OFFICE		
23 EMAIL ADDRESS	Month Day Year		



PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the dental insurance company for the purposes of identification and dental coverage processing.

It is **mandatory** to furnish all information requested on this form except for employee's gender and marital status, which may be furnished on a voluntary basis and are used by the dental insurance company for statistical and actuarial purposes. Failure to provide the **mandatory** information may result in the dental enrollment action not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151, 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the dental insurance company providing coverage for the employee. Copies of the Dental Plan Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Dental Plan Enrollment Authorization forms upon request. Send requests to: State Controller's Office, Personnel/Payroll Operations Bureau, P. O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.