The California State University

DENTAL PLAN ENROLLMENT AUTHORIZATION

D

CSU 692 (CSU Revised 03-2013)

PLEASE FORWARD COMPUTER-GENERATED FORM OR PRINT CLEARLY USING BALL POINT PEN. Send completed form to STATE CONTROLLER'S OFFICE PPSD, P.O. BOX 942850, SACRAMENTO, CA 94250-5878

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, and D

☐ CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE (Complete Sections A, B, C, and D)

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

ADDRESS (Number and Street)

(City, State, and Zip)

3. MARITAL STATUS

☐ MARRIED ☐ SINGLE ☐ REGISTERED DOMESTIC PARTNER (RDP)

4. GENDER ☐ MALE ☐ FEMALE

5. SOCIAL SECURITY NUMBER (EMPLOYEE SSN)

6. SPOUSE OR REGISTERED DOMESTIC PARTNER (RDP) SSN

Is RDP a Tax Dependent? ☐ Yes ☐ No

Tax Year

DP Dependent Certification Form On File? ☐ Yes ☐ No

SECTION B

1. NAME OF DENTAL PLAN

2. PROVIDER/FACILITY NUMBER (If applicable)

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) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

Action Code	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (inclining yourself) NAME	DATE OF BIRTH MO	DAY	YR	FAMILY RELATIONSHIP	GENDER
					SELF	
	SSN:					
	SSN:					
	SSN:					
	SSN:					

SECTION C

1. PRIOR DENTAL PLAN NAME

SECTION D - EMPLOYEE AND EMPLOYER AUTHORIZATION

1. Check one below:

☐ I AM WAIVING ENROLLMENT IN A DENTAL PLAN (ALSO APPLICABLE TO ENROLLMENT IN FLEXCASH DENTAL)

☐ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE PRE-TAX DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE (IF APPLICABLE) OF THE 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 CALIFORNIA STATE UNIVERSITY 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.)

3. DATE SIGNED

1. CSU DEDUCTION CODE	2. DENTAL ORG CODE	3. PARTY CODE	4. PAY PERIOD (MMYYYY)	5. CSU SHARE AMOUNT	6. EMPLOYEE SHARE	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT

PRIOR DENTAL PLAN INFORMATION

10. PRIOR CSU DEDUCTION CODE	11. PRIOR DENTAL ORG CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION	15. AGENCY CODE	16. UNIT CODE	17. CAMPUS NAME (IF ACTIVE EMPLOYEE) CALPERS RETIRED? Yes ☐ No ☐

18. **REMARKS:**

19. **AUTHORIZED CAMPUS BENEFITS OFFICE SIGNER (PLEASE PRINT)**

20. Telephone Number

21. **AUTHORIZED CAMPUS BENEFITS OFFICER SIGNATURE**

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting Benefits officer or authorized campus designee and that I am authorized to make this certification; that the employee (and any named dependents) named herein is eligible for enrollment in the CSU Dental Program.

22. **EMAIL ADDRESS**

23. DATE RECEIVED IN CAMPUS BENEFITS OFFICE (M/D/Y)

DISTRIBUTION: ORIGINAL - State Controller's Office COPY - Campus File COPY - Employee (with privacy notice)

California State University

DENTAL PLAN ENROLLMENT AUTHORIZATION

CSU 692 (REV. 03-2013) (REVERSE)

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.