CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Retiree Dental Plan Enrollment - Change Request

Retiree Dental Open Enrollment
State of California

Print Form Reset Form

PLEASE COMPLETE AND RETURN THIS FORM TO:

CalPERS Health Account Management Division P.O. Box 942715 Sacramento, CA 94229-2715
(888) CalPERS or (888) 225-7377 TTY (877) 249-7442 Fax (800) 959-6545

IF YOU HAVE NO COVERAGE CHANGES -- DO NOT RETURN THIS FORM

Event for Add/Change:

- ☐ I elect to enroll in a dental plan and authorize deductions, if applicable, to be made from my retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future.
- ☐ I do not wish to be enrolled in a dental plan offered to me as a state retiree.

1. Coverage Information

Member's Full Name (First, Middle, Last) | Member's SSN | Member's Birth Date

Member's Mailing Address (Street, City, State, ZIP)

Type of Action: ☐ New Enrollment ☐ Change ☐ Cancellation

Gender: ☐ Nonbinary ☐ Male ☐ Female

Member's Daytime Phone #

Name of Dental Plan (For Enrollments or Plan Changes)

Name of **Prior** State Dental Plan (For Plan Changes Only)

If Choosing a Pre-Paid Plan, Enter the Facility Number

2. Spouse or Domestic Partner

Marital Status | Domestic Partnership (Yes/No) | Spouse's or Domestic Partner's SSN

NOTE: To enroll a spouse, you must attach a copy of your marriage certificate and provide your spouse's Social Security Number. To enroll a domestic partner, you must attach a copy of the Secretary of State's required filing documents and provide your partner's Social Security number. To enroll a parent-child relationship (PCR) dependent, an Affidavit of Parent-Child Relationship CalHR-025 must be provided along with other supporting documentation as required.

3. Dependents

Name	Birth Date	Relationship	Add or Delete

If more dependents, attach additional pages; only eligible, authorized dependents may use the plan.

4. Signature

I have read and understand the general terms of enrollment.

Signature | Date Signed

PRIVACY NOTICE

This notice is provided pursuant to the Information Practices Act of 1977. The California Department of Human Resources (CalHR), Benefits Division, and the dental administrator are requesting the information specified on this form pursuant to Government Code sections 1151, 1153, section 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. The information collected will be used for administering the Dental Program.

Individuals should not provide personal information that is not requested or required. The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, CalHR will not be able to process your request for dental benefits.

Department Privacy Policy
The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy on CalHR's website (calhr.ca.gov).

Access to Your Information (maintained at the California Public Employees' Retirement System (CalPERS)
Information provided on the form will be forwarded to the dental company providing coverage. Copies of the RETIREE DENTAL PLAN ENROLLMENT - CHANGE REQUEST form are maintained in confidential files of CalPERS for five years. Individuals have the right of access to copies of their RETIREE DENTAL PLAN ENROLLMENT - CHANGE REQUEST form upon request. Send requests to:

CalPERS Health Account Management Division
P. O. BOX 942715
SACRAMENTO, CA 94229-2715