Santa Clara County Office of Education

DENTAL & VISION PLAN ENROLLMENT FORM

I. EMPLOYEE INFORMATION

DATE OF HIRE	DATE OF BIRTH	SOC. SEC. NO.	
LAST NAME	FIRST	MI	HOME PHONE (Including area code)
STREET ADDRESS	CITY	STATE ZIP	SEX (check) M ☐ / F ☐
Marital Status:	☐ Single ☐ Married ☐ Domestic Partner		

II. COVERAGE ELECTION (Complete dependent information section if coverage elected for spouse, children and/or domestic partner)

Delta Dental Election – Economy
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

Delta Dental Election – Core Plan
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

Vision Election –VSP
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

COVERED DEPENDENT INFORMATION –Dental, Vision

☐ Add ☐ Delete

NAME	SOCIAL SECURITY NUMBER	SEX M/F	DATE OF BIRTH	Over age 18 FULL TIME STUDENT
SPOUSE / DOMESTIC PARTNER				☐ Y ☐ N
DEPENDENT #1				☐ Y ☐ N
DEPENDENT #2				☐ Y ☐ N
DEPENDENT #3				☐ Y ☐ N
DEPENDENT #4				☐ Y ☐ N
DEPENDENT #5				☐ Y ☐ N

III. PRE-TAX PREMIUM DEDUCTIONS- Section 125 Premium Only Plan

☐	**You must make an active election for each calendar year. If you enrolled in one of these plans for the current calendar year, we will not automatically re-enroll you for the new calendar year. You must re-enroll each year.** Please check this box if you ***do not*** want your premiums deducted on a pre-tax basis

IV. RELEASE

I hereby certify that I am an eligible employee/beneficiary as defined in the Summary Plan Document that the above information is complete and accurate, and all claims submitted will be for individuals who are eligible members of the health plan. I hereby authorize the Plan Sponsor to deduct, from my pay, my contributions to the cost of the benefits, which I indicated above and for which I am or may become eligible. The current benefits have been explained to me thoroughly. I understand that I am responsible for a greater portion of my health costs in excess of the amounts payable under the plan.

THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTOOD, AND AGREE TO ALL SECTIONS AND THE TERMS OF THIS ENROLLMENT FORM.

EMPLOYEE SIGNATURE X _____ **(Required) DATE** _____

TO BE COMPLETED BY SANTA CLARA COUNTY OFFICE HUMAN RESOURCES ONLY			
☐ **Change** ☐ **New Hire** ☐ **Open Enrollment**		**Qualifying Event:**_____ **Qualifying Event Date:** _____ **Effective Date:**_____	
Medical Insurance	Date Entered	Delta Dental	Date Entered
QCC Updates	Date Entered	Vision	Date Entered