LOS ANGELES COMMUNITY COLLEGE DISTRICT

2015 ENROLLMENT/CHANGE FORM
DENTAL & VISION ONLY
RETIREES/ SURVIVORS

1. Personal Information

Last	First	MI	Social Security Number	Date of Birth

Street Address (no P.O. Boxes)			Home Phone	Cell Phone

City	State	Zip	Email Address

2. Retiree Contact Person – Someone who will always be able to contact you

Last	First	MI	Home Phone	Cell Phone

Address			relationship

City	State	Zip	Email Address

3. Reason for Completing This Form – Submit only if making changes.

☐ Open Enrollment

☐ Name/Address Change

☐ Change in Dependent Coverage

4. Dental Plan

☐ Delta Dental PPO

☐ MetLife Dental HMO (formerly Safeguard)

Coverage Type

☐ Retiree/Survivor only

☐ Retiree/Survivor + one

☐ Retiree/Survivor + Family

5. Vision Plan

☐ Vision Service Plan

Coverage Type

☐ Retiree/Survivor only

☐ Retiree/Survivor + one

☐ Retiree/Survivor + Family

6. Dependent Enrollment Information

Please complete the following section for each person you are enrolling, including yourself. If you are enrolling more than two children, please list their names and information on a separate page. Sign, date, and attach that page to this form.

Enrollee	Add	Delete	Name (Last on top line, First, MI)	Gender	Birth Date	Soc. Security #
Spouse/ Dom Partner	☐ Dental ☐ Vision	☐ Dental ☐ Vision				
Child/ Economic Dependent	☐ Dental ☐ Vision	☐ Dental ☐ Vision				
Child/ Economic Dependent	☐ Dental ☐ Vision	☐ Dental ☐ Vision				

NAME: _____ SSN: | | | | | | | | | |

7. How to Submit this Enrollment/Change Form

In order to enroll or change your plan, you must:

1. Complete *and* Sign this form.
2. If you are adding dependents, attach PHOTOCOPIES of 1) the social security card for all dependents. We allow a 90 day grace period for the card and number of newborns, and 2) A birth certificate (children), marriage certificate or domestic partner registration (spouse/dom partner). Domestic Partner is a registered same-sex partner or a registered inter-gender partner is one or bother persons in the relationship is over 62.
3. If you are deleting dependents, attach PHOTOCOPIES of dissolution of marriage or domestic partnership. If you have questions as to which documents are needed for verification, contact the Health Benefits Unit by telephone at (888) 428-2980 or via email at do-sap-benefits-health@email.laccd.edu.
4. Send this form and the attached PHOTOCOPIES of verification documents using ***one*** of the following methods:

US Mail	*Secure Fax*	*Email*
LACCD Health Benefits Unit 770 Wilshire Blvd., 6th Floor Los Angeles, CA 90017	**Health Benefits Unit** (213) 891-2008	**Use address in #3**

_____ ***initial*** I understand that the elections I make on this form will remain as long as I am eligible or until I make another election during annual enrollment. I am enrolling for myself and those eligible dependents that I have listed in Part 6 of this form for coverage under the plan(s) I have selected.

_____ ***initial*** ***I understand that I am responsible for reporting any change(s) in the eligibility status of my dependents within 60 days***. Further, if I fail to report status changes within 60 days, I understand that I could be liable for retroactive premium payments in excess of the amount of my plan if I had reported the change in time, and I further understand that I could be liable for medical expenses incurred by the ineligible party.

_____ ***initial*** I understand that missing documentation will result in a delay in processing that will leave me and/or my dependents without coverage until all information is submitted, and I further understand that my benefits become effective *after* I submit all documents to complete the enrollment process.

X _____ _____

Signature ***Date***

FOR HEALTH INSURANCE SECTION USE

Event Date: _____

Date Processed: _____

Processed By: _____