COUNTY OF SANTA CRUZ DENTAL AND VISION ENROLLMENT FORM

Employee Name: _____ Social Security Number: _____

Residence Address: _____ Employee Payroll #: _____

City, State, Zip: _____ Sex: ☐ Male ☐ Female ☐ Non-binary

Email Address: _____ Married: ☐ Yes ☐ No

Dental (3 Plans):

☐ Delta Preferred Option (*Basic PPO Option, No Cost*)

☐ Delta DPO+ (*Buy-Up PPO Option, $24 per pay period*)

☐ Cigna Dental Care Access (*DHMO, No Cost)*

Vision (1 Plan):

☐ VSP Employee Vision *(No Dependents, No Cost)*

☐ VSP Dependent Vision *($8.92 per pay period)*

Enroll or delete my dependent(s) as listed below:

Dependent(s) Name (First, MI, Last)	Social Security #	Date of Birth (mm/dd/yyyy)	Family Relationship	Add Dental	Delete Dental	Add Vision	Delete Vision

If I elect H-CARE option 2, 3, or 4 below, I must have an H-CARE (Medical Premium Pre-Tax Program) enrollment form on file in addition to be enrolled in a medical plan. I realize that any additional cost for these options will be added to the amount of my medical contribution cost and pre-taxed each pay period (and will not be a separate line-item deduction). I understand that this information is available for my review on my earnings statement (pay-stub). ***If you are not enrolled in H-CARE and a medical plan, these options DO NOT apply to you.***

I select the following H-Care Option (Pre-tax Dependent Vision and/or Buy Up Dental costs with your medical premiums):

☐ **#2** Dependent Vision and Medical ☐ **#3** DPO+ Dental and Medical ☐ **#4** Dependent Vision, DPO+ Dental and Medical

If I elect to enroll my dependent(s) in the vision plan, I authorize deductions to be made from my salary to pay the cost* of dependent enrollment. I also understand that my dependent(s) must remain on the vision plan for the entire plan year. No cross coverage is permitted.

If I elect to enroll in Delta DPO+, I authorize deductions to be made from my salary to pay the cost* of this buy-up option. I also understand that I and my dependent (s) must remain on the Delta DPO+ plan for the entire plan year.

H-Care option selections remain in effect for the entire plan year (unless employee goes on an unpaid status) and can be changed during open enrollment.

*Cost subject to change and is communicated to employee during the open enrollment period each year.

Employee Signature Primary Phone Date (mm/dd/yyyy)

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*****This Section for Benefits Office Use Only*****:

Comments: _____

Certificate(s) on file: ☐ Marriage ☐ DP ☐ Birth ☐ Other

Permitting Event Date (mm/dd/yyyy)	Effective Date (mm/dd/yyyy)	HBO Rec'd Date (mm/dd/yyyy)	Bargaining Unit	HBO Initials (mm/dd/yyyy)	Supervisor Approval (mm/dd/yyyy)

Rev: 04/2022