County of Santa Cruz
Dental and Vision Enrollment Form

Employee Name:_____ Social Security Number:_____

Mailing Address:_____ Payroll Number:_____

City, State, Zip:_____ Married: ☐ Yes ☐ No

Email Address:_____ Gender: ☐ Male ☐ Female ☐ Non-Binary

Dental (3 plan options)

☐ 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 option)

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

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

Dependent(s) Name First, MI, Last	Social Security Number xxx-xx-xxxx	Date of Birth mm/dd/yyyy	Family Relationship (Spouse, Child etc.)	Gender (M, F, NB)	Add Dental	Add Vision	Delete Dental	Delete Vision

H-Care Participants: H-Care (Medical Premium Pre-Tax Program) participants have their medical cost deducted from their income on a pre-tax basis each pay period. These participants are also eligible to have their costs for Delta DPO+ and Dependent Vision added to their medical cost on a pre-tax basis each pay period.

You must have an H-Care Enrollment Form on file and be enrolled in a County medical plan to participate. If you are not enrolled in H-Care and a County medical plan, these options do not apply to you.

H-Care Selection: Choose an option that applies to the dental and vision selection made above.

☐ Option 2: Medical and VSP Dependent Vision

☐ Option 3: Medical and Delta DPO+ Dental

☐ Option 4: Medical and Delta DPO+ Dental and VSP Dependent Vision

- I understand and authorize the additional costs for enrolling in Delta DPO+ and/or Dependent Vision, are added to the medical cost and deducted from my income on a pre-tax basis each pay period.
- Due to the tax implications of this pre-tax program, I understand that I must remain enrolled in Delta DPO+ and/or Dependent Vision for the entire plan year*.

*H-Care enrollment remains in effect for the entire plan year. If the employee goes on an unpaid status, the enrollment terminates. The employee can re-enroll in this pre-tax program during open enrollment.

Employee Signature | Primary Phone Number | Date

Office use:

On file: _Marriage _DP _Birth _SSN _Other Notes:

Permitting Event Date	Effective Date	HBO Rec'd Date	Bargaining Unit	HBO Initials	Supervisor Approval