STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 4/2024)

Clear Print

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1. TYPE OF ACTION

- ☐ **NEW** - ENROLLING IN A PLAN FOR THE FIRST TIME (*Complete Sections A, B, and D*)
- ☐ **CANCEL** – *(Complete Sections A, C, D)*
- ☐ **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*
- ☐ **COBRA** - ENROLLING IN COBRA CONTINUATION COVERAGE (*Complete Sections A, B, and D*)

2. NAME *(First)* *(Middle)* *(Last)*

ADDRESS *(Number and Street)*

(City, State, and Zip)

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE ☐

4. MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

5. GENDER ☐ MALE ☐ FEMALE ☐ NONBINARY

6. SOCIAL SECURITY NUMBER

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER

SECTION B

1. NAME OF DENTAL PLAN

2. PROVIDER/FACILITY NUMBER *(If applicable) (prepaid plans only)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDES THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) *(First) (Middle) (Last)*	DATE OF BIRTH (MM/ DD/ YY)	DEPENDENT TYPE	GENDER
			SELF	
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			
	SSN			

Dependent Type:
S - Spouse DP - Domestic Partner C - Child SC - Stepchild DC - Disabled Child
DPC - Domestic Partner Child PCR - Parent-child Relationship

SECTION C *(Complete for Plan changes if different than B-1 and cancellations only)*

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

☐ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE (*See Privacy Information on reverse of employee copy*)

3. DATE SIGNED

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED.CODE	2. DENTAL ORG. CODE	3. PARTY CODE	4. PAY PERIOD MONTH YEAR	5. STATE SHARE AMOUNT	6. EMPLOYEE or COBEN DEDUCTION AMOUNT	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
☐ CSU-150 ☒ NON-CSU-351				$	$			$

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE (MM / DD /YY) MONTH DAY YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (*IF RETIRED*)
☐ CSU-150 ☒ NON-CSU-351					1			☒ CAL FIRE AGENCY ☐ CALPERS RETIREE

18 REMARKS

19. SIGNING PERSONNEL OFFICER'S NAME (*Please Print*)

20. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employees named herein is eligible for enrollment in the State Dental Insurance Program.

21. TELEPHONE NUMBER *(Include Area Code)*
(831) 335-5353

23. EMAIL ADDRESS
CZUHumanResources@fire.ca.gov

22. DATE RECEIVED IN EMPLOYING OFFICE
Month Day Year

Distribute one copy each to Controller, Carrier, Agency, and Employee

Clear Print

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PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the dental insurance company for the purposes of identification and dental coverage processing.

It is **mandatory** to furnish all information requested on this form except for employee's gender and marital status, which may be furnished on a voluntary basis and are used by the dental insurance company for statistical and actuarial purposes. Failure to provide the **mandatory** information may result in the dental enrollment action not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151, 1153, Sections 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.

Information provided on the form will be forwarded to the dental insurance company providing coverage for the employee. Copies of the Dental Plan Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Dental Plan Enrollment Authorization forms upon request. Send requests to: State Controller's Office, Personnel/Payroll Operations Bureau, P. O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.