D Retired Dental Application Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

United Concordia dental®

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

COVERAGE INFORMATION

Member's Full Name (First, Middle, Last)	Member's SSN	Member's Birth Date

Member's Mailing Address (Street, City, State, ZIP)

Type of Action:	Sex:	Member's Daytime Phone #
☐ New Enrollment ☐ Change ☐ Cancellation	☐ Male ☐ Female	

Name of Dental Plan (For Enrollments or Plan Changes)	Prior State Dental Plan (For Plan Changes Only)
CCPOA RETIRED DENTAL PLAN - United Concordia	**IF YOU ARE CURRENTLY RETIRED AND ENROLLED THROUGH CALPERS, YOU MUST CANCEL YOUR CALPERS DENTAL PLAN TO AVOID DOUBLE BILLING**

SPOUSE OR DOMESTIC PARTNER

Marital Status	Domestic Partnership (Yes/No)	Spouse's or Domestic Partner's SSN
☐ MARRIED ☐ UNMARRIED	☐ YES ☐ NO	

NOTE: *YOU MAY BE REQUIRED TO VERIFY DEPENDENTS THROUGH THE ELECTRONIC ENROLLMENT PROCESS.*

DEPENDENTS

Name	Birth Date	SSN	Relationship

IF MORE DEPENDENTS, ATTACH ADDITIONAL PAGES; ONLY ELIGIBLE, AUTHORIZED DEPENDENTS MAY USE THE PLAN..

■ **Plan Selection** at current monthly rate (Check One)
☐ **Retired Member Only** $38.66
☐ **Retired Member and One dependent** $82.54
☐ **Retired Member and Two or more dependents** $141.07

There is currently no state contribution for this plan. Rates may change, pending any MOU negotiations.

I hereby authorize the CalPERS to deduct from my salaries and wages the amount specified now or in the future for membership dues and any benefit program for which I have applied, which is sponsored by the California Correctional Peace Officers Association (CCPOA). This authorization will remain in effect until canceled by me or by CCPOA. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.

Fraud Notice – For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Applicant:	**Date of Application:**
X	

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

RETIRED