Retiree and Survivor Enrollment or Change Form

Los Angeles Community College District

Dental and Vision Only

Instructions

1. Adding dependents: Attach copies 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 or domestic 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.
2. 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 email at healthbenefits@email.laccd.edu.
3. Send this form and the attached Photocopies of verification documents using **one** of the following methods:

US Mail
LACCD Health Benefits Unit
770 Wilshire Blvd., 6th Floor
Los Angeles, CA 90017

Secure Fax
Health Benefits Unit
(213) 891-2008

1. Personal Information

Last ____

First ____

Middle Initial ____

Street Address (no P.O. Boxes) ____

City ______________________________

State ______________________________

Zip ______________________________

Social Security Number ______________________________

Date of Birth ______________________________

Home Phone ______________________________

Cell Phone ______________________________

Email Address ______________________________

2. **Reason for Completing This Form** (Select all that apply.)

- ☐ Open Enrollment
- ☐ Name or Address Change
- ☐ Change in Dependent Coverage

3. **Dental Plan** (Select all that apply.)

- ☐ Delta Dental PPO
- ☐ MetLife Dental HMO (formerly Safeguard)

4. **Vision Plan** (Select all that apply.)

- ☐ Vision Service Plan

5. Dependent Enrollment Information

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

Spouse or Domestic Partner Enrollee Details

Add (Select all that apply.)

☐ Dental ☐ Vision

Delete (Select all that apply.)

☐ Dental ☐ Vision

Last Name	First Name and Middle Initial	Gender	Birth Date	Social Security Number

Child or Economic Dependent Enrollee Details

Dependent	Add (Select all that apply)	Delete (Select all that apply.)	Last Name	First Name and Middle Initial	Gender	Birth Date	Social Security Number
1	☐ Dental ☐ Vision	☐ Dental ☐ Vision					
2	☐ Dental ☐ Vision	☐ Dental ☐ Vision					
3	☐ Dental ☐ Vision	☐ Dental ☐ Vision					

In order to enroll or change your plan, you must sign and date form:

Signature ____

Date ____