2027 CITY OF NEWPORT BEACH RETIREE OPEN ENROLLMENT FORM

SECTION 1: ELECTION OF DENTAL AND VISION BENEFITS			
DELTA DENTAL DHMO:	☐ Participant Only	☐ 2-Party	☐ Family
DELTA DENTAL PPO (HIGH):	☐ Participant Only	☐ 2-Party	☐ Family
DELTA DENTAL PPO (LOW):	☐ Participant Only	☐ 2-Party	☐ Family
VSP VISION PPO:	☐ Participant Only	☐ 2-Party	☐ Family

SECTION 2: SUBSCRIBER INFORMATION *(provide all requested information below regarding the primary subscriber)*			
LAST NAME:	FIRST NAME:	DATE OF BIRTH:	
SOCIAL SECURITY NUMBER:	FORMER EMPLOYEE ID:	MALE: ☐ FEMALE: ☐	
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ REGISTERED DOMESTIC PARTNER (RDP) ☐ DIVORCED ☐ LEGALLY SEPARATED			
STREET ADDRESS:	CITY:	STATE:	ZIP:

SECTION 3: DEPENDENT INFORMATION *(list all eligible family members to be enrolled – attach additional sheets if necessary)*				
☐ Spouse ☐ RDP	LAST NAME:	FIRST NAME:		MI:
	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:		MALE: ☐ FEMALE: ☐
	ADDRESS: ☐ *check if same as employee*	STREET ADDRESS:		
		CITY:	STATE:	ZIP:
	THIS DEPENDENT SHOULD BE ENROLLED IN: ☐ DENTAL ☐ VISION			
Child	LAST NAME:	FIRST NAME:		MI:
	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:		MALE: ☐ FEMALE: ☐
	IF APPLICABLE, OVERAGE DEPENDENT TYPE (IF APPLICABLE): ☐ DISABLED ☐ UNDER AGE 26			
	ADDRESS: ☐ *check if same as employee*	STREET ADDRESS:		
		CITY:	STATE:	ZIP:
	THIS DEPENDENT SHOULD BE ENROLLED IN: ☐ DENTAL ☐ VISION			
Child	LAST NAME:	FIRST NAME:		MI:
	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:		MALE: ☐ FEMALE: ☐
	IF APPLICABLE, OVERAGE DEPENDENT TYPE (IF APPLICABLE): ☐ DISABLED ☐ UNDER AGE 26			
	ADDRESS: ☐ *check if same as employee*	STREET ADDRESS:		
		CITY:	STATE:	ZIP:
	THIS DEPENDENT SHOULD BE ENROLLED IN: ☐ DENTAL ☐ VISION			

SECTION 4: AUTHORIZATION	
The information is complete and correct to the best of my knowledge. During the election period, I authorize BCC to make changes to my benefits as stated on this form. I understand that any changes postmarked after the election period will not be honored, and therefore my enrollment changes in the Retiree benefit program will not be processed.	
SIGNATURE:	DATE:

FOR INTERNAL USE ONLY:	
DATE ENTERED INTO SYSTEM:	ENTERED BY:

QUESTIONS? Call BCC's Customer Service Call Center at 800-685-6100

BCC
Trusted Solutions. Real Results.