DELTA DENTAL

CSU The California State University

Request for direct payment authorization or termination of enrollment for dental plans

Part A Employee information

1. **Last name:** _____ **First name:** _____ **Middle initial:** _____
2. **Social security number:** _____ 3. **Phone number:** _____
4. **Mailing address:** _____

   City: _____ **State:** _____ **ZIP:** _____
5. **Dependent:**

   Name: _____ **Date of birth:** _____ **Social security number:** _____

   Name: _____ **Date of birth:** _____ **Social security number:** _____

   Name: _____ **Date of birth:** _____ **Social security number:** _____

   Additional dependents can be listed on page 2.

Part B Employee to sign to decline continued coverage

6. **Employee's signature:** _____ 7. **Date:** _____

Part C Employee to sign to request continued coverage

8. I request continuance of my dental plan coverage during the time I will be temporarily off pay status. I agree to make direct payment of the total premium to my dental plan carrier. I understand that failure to make timely premium payments and/or failure to notify the carrier of loss of eligibility during my leave status will result in termination of my coverage and the carrier's liability while off pay status. I understand that I will not be billed by the carrier and that I must pay the premium for the month in which I return to pay status.

   I agree to pay Delta Dental (Please check appropriate plan):

☐ **Delta Dental of California**
P.O. Box 884460
Los Angeles, CA 90088-4460
Attention: Direct Payment — E&B
PPO policy number: 4018
Contact PPO: 800-626-3108

☐ **Delta Dental of California**
P.O. Box 660138
Dallas, TX 75266-0138
Attention: D2C — Direct Payment
DHMO policy number 72034
Contact DeltaCare: 844-519-8751

A total of $ _____ each quarter ($ _____ per month x 3 months), in advance, beginning with the month of _____, 20 _____.* **Check must be made payable to Delta Dental**, prior to the tenth (10th) of the month immediately preceding the beginning of each quarter. I understand that if I return to active services before completion of a paid quarter, refund will be made only for full months of overpayment. (Partial months cannot be refunded.)

9. **Employee's signature:** _____ 10. **Date:** _____

Note: The campus needs to fill out the reverse side of this form.

*** If the time in non-pay status is less than three months, only the actual premium must be paid.**

Dependent:

Name: _____ Date of birth: _____ Social security number: _____

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Name: _____ Date of birth: _____ Social security number: _____

Name: _____ Date of birth: _____ Social security number: _____

Part D Reason for Direct Pay

11. Last name: _____
12. Dates of absence: From _____ to _____
13. Last pay period premium deduction was made or will be made: _____
14. Employee to pay for the months of _____ through _____
15. Employment information:

    Campus: _____ Address: _____

    Agency code: _____ Employee's bargaining unit code: _____
16. I certify that all of the above information is correct according to our records:

    Signature of benefits officer: _____ Date: _____

    Phone number: _____

Distribution:

- If employee chooses not to continue, one copy to employee and one to file.
- If employee chooses to direct pay, one copy to employee, one to file and one to carrier.
- Direct Pay enrollment form must be sent with initial payment.