Delta Dental Plans – Authorizations/Agreements

I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract. In addition, I agree to the follow authorizations:

Deduction Authorization: I hereby authorize San Diego Unified School District to pay the dental benefits premiums for me and my eligible dependents (if applicable) to the plan checked above until changed or revoked by me in writing. I also authorize San Diego Unified School District to deduct from my salary the amount necessary, if any, to pay for my dental coverage not paid by the district and to transmit the same to the above-named plan.

Authorization to Obtain or Release Medical Information (Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et.seq. of the California Civil Code): I hereby authorize my dentist, physician, health care practitioner, hospital, clinic, or other medical or medically-related facility to furnish an agent, designee or representative of the dental plan in which I am enrolling as indicated above, any and all records pertaining to medical/dental history, services rendered or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation or evaluation of an application or a claim. I authorize such carriers or their agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical/dental information obtained, if such disclosure is necessary, to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to allow the processing of any claim.

Arbitration Agreement: I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled eligible dependent) and Delta Dental PPO Plan or Delta Care USA Dental whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

Dependent Coverage: I have read and understand the provisions on this form pertaining to dependents who are eligible to be included in my dental coverage. I hereby certify that the individuals listed on this enrollment form, if any, meet those provisions. Additionally, I understand that dependents not listed on this enrollment form may be added only by submitting appropriate forms to the Employee Benefits Department within 31 days of the date the dependent becomes eligible for coverage or during the annual Open Enrollment period held in the fall.