



**11230 Sorrento Valley Road  
Suite 105  
San Diego, CA 92121  
(800) 733-4487  
(858) 622-5000**

### **Application Instructions:**

- Complete all sections of the application with signature and date.
- Complete Authorization for Direct Automatic Bill Payment form.
- Enclose a voided check. (Deposit slips will not be accepted)
- Mail package to:

Pacific Financial Designs, Inc.  
11230 Sorrento Valley Road  
Suite 105  
San Diego, CA 92121  
Attn: New Benefits

- All enrollments received by the 15<sup>th</sup> of the month will be effective the 1<sup>st</sup> of the following month. Those received after the 15<sup>th</sup> will not be processed until the following month with an effective date of the following 1<sup>st</sup> of the month.
  - Example: Application received on August 14<sup>th</sup> will be effective September 1<sup>st</sup>, but an application received on August 17<sup>th</sup> will be effective October 1<sup>st</sup>.

**RETIRED PEACE OFFICERS ASSOCIATION of CALIFORNIA**

**DENTAL BENEFITS APPLICATION**

**GENERAL INFORMATION**

Name (Last, First, MI)	ID #	Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (MM/DD/YY)	Date of Retirement	Policy Number 715049
Member's email address	Event <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other:	Apt./Unit #	City	Effective Date of Coverage	Home Phone #	
Residence Mailing Address				Zip	State	

**DENTAL ENROLLMENT**

Choose from the following dental plans.  
(  the box that applies)

Pacific Union Dental (CA only) Imperial	HMO Dental UHC/PacificCare (CA only)	PPO Dental UnitedHealthcare
Monthly <input type="checkbox"/> \$24.88 <input type="checkbox"/> \$42.55 <input type="checkbox"/> \$63.45 <input type="checkbox"/> 0001	Monthly <input type="checkbox"/> \$13.61 <input type="checkbox"/> \$25.76 <input type="checkbox"/> \$39.32 <input type="checkbox"/> 0002	Monthly <input type="checkbox"/> \$31.76 <input type="checkbox"/> \$62.30 <input type="checkbox"/> \$104.22 <input type="checkbox"/> 0003

**MEMBER/DEPENDENT INFORMATION**

Name (Last, First, MI)	Relationship	Gender	Date of Birth (MM/DD/YY)	Full-time Student	Dental Provider Name & City (HMO Only)	Patient Existing	Group # (HMO) Dental Provider
	Member					<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you or your dependents have any other dental insurance? If "Yes", complete the following information:

Benefit	Insurance Company	Policy #	Who is covered under this other policy?
<input type="checkbox"/> Dental			
<input type="checkbox"/> Dental			
<input type="checkbox"/> Dental			

**Signature**

I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY ASSOCIATION TO MAKE THE NECESSARY DEDUCTION(S) FROM MY MEMBERSHIP TO PAY MY PORTION OF THE PREMIUM.

ARBITRATION DISCLOSURE: I agree that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and United HealthCare, Pacific Union Dental and PacificCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)

# AUTHORIZATION FOR DIRECT AUTOMATIC BILL PAYMENT

Company Name: Benefit Service Center, Inc. (the "Company")

I (we) authorize the Company to initiate variable entries to my (our) account described below:

Checking Acct. No. \_\_\_\_\_ Savings Acct. No. \_\_\_\_\_

Financial Institution Name: \_\_\_\_\_

Financial Institution Address: \_\_\_\_\_

Attach a voided check here

This authority is to remain in full force and effect until the Company has received written notification from me (or either one of us) of its termination in such time and manner to afford the Company a reasonable opportunity to act on it.

Signature _____	(Optional - For Joint Account)
Full Name _____	Signature _____
Address _____	Full Name _____
_____	Date _____
Date _____	Telephone _____
Telephone _____	
Policy No. _____	

<i>Office Use Only</i>	
Representative _____	First Batch _____
Agent _____	Notes _____
Policy _____	