County of Santa Cruz
Dental and Vision Enrollment Form

Employee Name:_____ Employee Payroll #:_____

Mailing Address:_____ SSN:_____

City, State, Zip:_____ Married: ☐ Yes ☐ No

Email Address:_____ Gender: ☐ Male ☐ Female ☐ Non-Binary

Dental (3 plan options)

☐ Delta Dental PPO Basic *(No Cost)*

☐ Delta Dental PPO Buy-up *($24 per pay period)*

☐ Cigna Dental Care Access HMO *(No Cost)*

Vision (1 plan option)

☑ VSP Employee Only Vision *(No Cost)*

☐ VSP Dependent Vision *($8.92 per pay period)*

Dependent(s) Name First, MI, Last	Social Security Number xxx-xx-xxxx	Date of Birth mm/dd/yyyy	Family Relationship (Spouse, Child etc.)	Gender (M, F, NB)	Add Dental	Add Vision	Delete Dental	Delete Vision

H-Care participants will have their medical premium deducted from their income on a pre-tax basis each pay period. These participants are also eligible to have their costs for Delta Dental PPO Buy-up and VSP Dependent Vision included in their medical cost on a pre-tax basis each pay period. **Requirements: 1) You must have an H-Care Enrollment Form on file and 2) you must be enrolled in a County medical plan. If you are not enrolled in H-Care AND a County medical plan, these options do not apply to you.**

Add these expenses to my H-Care: **[Choose the option(s) that applies to your selection(s) above.]**

☐ Add VSP Dependent Vision to H-Care with my pre-tax medical cost.

☐ Add Delta Dental PPO Buy-up to H-Care with my pre-tax medical cost.

- I understand and authorize the additional costs for enrolling in Delta Dental PPO Buy-up and/or VSP Dependent Vision are added to the medical cost and deducted from my income on a pre-tax basis each pay period.
- Due to the tax implications of this pre-tax program, I understand that I must remain enrolled in Delta PPO Buy-up and/or VSP Dependent Vision for the entire plan year*.

**H-Care enrollment remains in effect for the entire plan year. If the employee goes on an unpaid status, the H-Care enrollment terminates. The employee may re-enroll in this pre-tax program only during open enrollment.*

Employee Signature Date Phone #

Office use:

On file: _Marriage _DP _Birth _SSN _Other Notes:_____

Permitting Event Date	Effective Date	HBO Rec'd Date	Bargaining Unit	HBO Initials	Supervisor Approval

Rev. 08/2025