Oakland Firefighters Health & Welfare Trust

Health Services & Benefits Administration
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756
(925) 833-7313
OaklandFireDental@HSBA.com

APPLICATION TYPE:

☐ New Hire ☐ Retire/Reinstatement ☐ Birth/Adoption ☐ Partner/Divorce ☐ Open Enrollment

☐ Marriage/New Domestic ☐ Loss of Coverage ☐ Other__________

YOUR PERSONAL INFORMATION:

First Name:	Last Name:		Middle Int:
Street Address:	City:	State:	Zip:
Social Security #:	Date of Birth:	Gender: ☐Male ☐Female	
Email Address:	HM Telephone #:	Cell #:	

DEPENDENTS INFORMATION:

Add Drop	Full Name:	Social Security #:	Date of Birth:	Relationship:
Add ☐ Drop ☐	Full Name:	Social Security #:	Date of Birth:	Relationship:
Add ☐ Drop ☐	Full Name:	Social Security #:	Date of Birth:	Relationship:
Add ☐ Drop ☐	Full Name:	Social Security #:	Date of Birth:	Relationship:
Add ☐ Drop ☐	Full Name:	Social Security #:	Date of Birth:	Relationship:
Add ☐ Drop ☐	Full Name:	Social Security #:	Date of Birth:	Relationship:

To add or change a dependent, the following documents are required and must be submitted with your enrollment forms:

- Copies Of Marriage Certificate Or Divorce Papers
- Certificate Of Domestic Partnership Issued By Governmental Agency
- Copies Of Birth Certificates For Dependent Children
- Foster & Adopted Children: Legal Guardianship Or Court Adoption Papers

Upon completed enrollment you will automatically be enrolled into the Oakland Firefighters Dental Plan, Please refer to the Oakland Firefighters Health and Welfare Trust Fund Summary Plan Description (SPD) Effective May 1, 2013, for information regarding Plan Rules, Eligibility and Coverage.

I certify that information on this document is true and correct and I give my permission to verify any and all information. I agree to assume full financial responsibility for all expenses and to reimburse and indemnify the plan and the City of Oakland for any benefits paid for myself and/or my dependents if I or my dependents subsequently prove to be ineligible to participate in the plans or to receive such benefits. I also understand that the facilitation of information on this document may violate applicable laws, rules and regulations and could lead to disciplinary action, dismissal and/or legal action. I have read and accept the terms and conditions of the Dental Plan Rules and Regulations included in the Summary Plan Description (SPD)

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Print Full Name **Signature** **Date**