Laborers Funds Administrative Office of Northern California, Inc.
5672 Stoneridge Drive, Suite 100, Pleasanton, CA 94588 | Telephone: 707-864-2800 or 800-244-4530

Dental and/or Vision Option Election Form
Effective March 1, 2025

IMPORTANT:

To enroll in any of the optional dental and/or vision plans offered by the Laborers Health and Welfare Retired Plan, this authorization form must be returned to the Fund Office along with the enclosed Retired Plan Benefit Application Form for Medical-Hospital and Prescription Drug coverage.

DO NOT COMPLETE THIS FORM IF YOU ELECTED NOT TO PARTICIPATE IN THE MEDICAL-HOSPITAL AND PRESCRIPTION DRUG COVERAGE.

☐ **A**. In addition to Medical/Hospital/Prescription Drug coverage that I elected, see enclosed Retired Plan Application Form, I also wish to enroll in a **DENTAL PLAN BELOW** (select and mark X):

☐ Anthem Blue Cross Dental Complete for a monthly premium of $75.00

☐ DeltaCare USA for a monthly premium of $40.00. You must select a dental office from DeltaCare USA's participating dental offices directory:
Name of Dental Office: _____ Facility No.: _____

AND/OR A VISION PLAN BELOW (select and mark X):

☐ Anthem Blue Cross Blue View Vision for a monthly premium of $11.00

☐ Kaiser Vision Essentials for a monthly premium of $7.00
You must be enrolled in Kaiser Permanente to elect this option.

☐ **B**. I **DO NOT** wish to receive dental and vision coverage**. I understand that I may not be given the opportunity to elect this coverage again.**

*I hereby authorize the Laborers Funds Administrative Office of Northern California that administers my Pension Plan to deduct the appropriate premium amount from my monthly pension benefit (or I will send a payment if my monthly pension benefit is less than the premium amount or I am not receiving a pension benefit from any Pension Plans administered by the Fund Office) for the optional coverage I elected under the Laborers Health and Welfare Retired Plan. The monthly rates indicated above are effective March 1, 2025 and are subject to change. I understand that I am allowed to change dental and vision plans every March 1. I understand that by electing the optional dental and/or visio coverage, I must pay for this coverage for a minimum of **6 months**. I further understand that if I cancel the dental and/or vision coverage **prior to** the minimum 6-month period, I will also be canceling my Medical-Hospital and Prescription Drug coverage.*

Important: If you enroll in DeltaCare USA, any dispute that may arise between you and the Dental Plan will be subject to binding arbitration.

_____	_____
Signature	**Date**
_____	_____
PRINT Name	**Social Security Number**