DELTA DENTAL
Delta Dental Insurance Company

DUAL CHOICE ENROLLMENT/CHANGE FORM

PMI DENTAL HEALTH PLAN
An Affiliate of Delta Dental Plan of California

For Employer Use Only	
Effective Date / /	Group No.
Full Time Hire Date / /	Sublocation

Select a Program: Delta Dental ❑ DeltaCare* ❑ (Not available in all areas)

*DeltaCare is administered by Private Medical-Care, Incorporated (PMI).

Check One

(**Enrollees can change plans only during open enrollment)

- ❑ New Hire
- ❑ Open Enrollment
- ❑ Change Dental Plans**
- ❑ COBRA
- ❑ Add/Delete Dependent
- ❑ Terminate Employee Coverage
- ❑ Spouse Employment Change
- ❑ Marital Change
- ❑ Other _____

Indicate qualifying date: (Month) (Day) (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce
- ❑ Widowed/Surviving Dependent
- ❑ Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

- ❑ **Delta Dental** - CANCEL
- ❑ **DeltaCare** - CANCEL

Delta Dental - 1-800-521-2651
DeltaCare - 1-800-422-4234

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last, First, Middle)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Social Security # ___ — ___ — ___ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group Location

Marital Status: Single ❑ Married ❑ Gender: Male ❑ Female ❑ Phone # ( ) —

Do you have dependent children? Yes ❑ No ❑ Are you or your dependents covered under another dental plan? Yes ❑ No ❑

Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF
(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth: (Month) (Day) (Year)
Spouse:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	
Dependent:	❑	❑	❑	❑	

DeltaCare

Dentist Name: Provider # Location (State)

- ❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.
- ❑ I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee _____ Date _____