Dental/Vision Enrollment Form

Dual Choice Enrollment Form

For Delta Dental Internal Use Only	Group Name:	**For PMI Internal Use Only**
Group/Employer Number:		Group/Employer Number :
Coverage Type Code:	Group Division/Number:	ID Number:
Effective Date:		Effective Date:

Please select the plan(s) you wish to enroll in:

☐ **DeltaCare® USA**
PMI Dental Health Plan, an Affiliate of Delta Dental
Dental HMO Plan
Delta Care Region:
You must select a network dentist for this plan
Dental Office Name:
Dental Office Phone Number:

☐ **Delta Dental PPO℠**
Delta Dental of California
Dental fee-for-service plan

☐ VSP individual vision plans

Primary Enrollment Information
Name:
Address:
City, State, Zip:
Home Phone: (   )
E-mail Address:
Date of Birth: / /
☐ Male ☐ Female
Social Security Number:

Action Requested:
☐ New enrollment
☐ Add dependent
☐ Remove dependent
☐ Name change
☐ Address change
☐ Social Security Number correction

☐ **COBRA Enrollment Only**
I understand that I may be required by the employer to pay for COBRA benefits.

Note: If dependent is enrolling under own Social Security Number, the original enrollee's Social Security Number must be provided.
Primary enrollee's SSN: - -
Qualifying Date: / /
Qualifying Reason:

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated
Do you have dependent children?
☐ Yes ☐ No
Does your spouse have a dental plan?
Yes ☐ No ☐
☐ Yourself
☐ Spouse
☐ Dependent children
If Delta Dental, indicate Group Number

Date Employed:
/ /

Employee Classification:
☐ Full-time
☐ Part-time
☐ Salaried
☐ Hourly
☐ Certificated
☐ Classified
☐ Retired
☐ COBRA

Dependent Information:

Spouse Name, (Last, First MI)	Spouse' Social Security Number:	Date of Birth:	Marriage/Divorce Date:	
	- -	/ /	/ /	☐ Male ☐ Female

Children:

Name, (Last, First MI)	Child Social Security Number	Date of Birth	If 19 or older, indicate Full-time student	Disabled	
	- -	/ /	☐	☐	☐ Male ☐ Female
	- -	/ /	☐	☐	☐ Male ☐ Female
	- -	/ /	☐	☐	☐ Male ☐ Female
	- -	/ /	☐	☐	☐ Male ☐ Female

For PMI enrollees only:

Code*:	Dental Office Name:	Phone Number:

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***Relationship Code: Spouse- SP Domestic Partner- DP Child- CH Child of DP-CD Other Adult-OA Other Child-OC**

I understand that I may be required to pay for these benefits and those of my dependents. I agree to continue membership in the plan(s) selected above during employment and while the program is in force. I further agree to comply with the terms of the group contract.

Enrollee Signature: ______________________ Date: ____________