

## Dental/Vision Enrollment Form Dual Choice Enrollment Form

<b>For Delta Dental Internal Use Only</b> Group/Employer Number: _____ Coverage Type Code: _____ Effective Date: _____	Group Name: _____  Group Division/Number: _____	<b>For PMI Internal Use Only</b> Group/Employer Number : _____ ID Number: _____ Effective Date: _____
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Please select the plan(s) you wish to enroll in:

<input type="checkbox"/> <b>DeltaCare® USA</b> PMI Dental Health Plan, an Affiliate of Delta Dental Dental HMO Plan Delta Care Region: _____ <i>You must select a network dentist for this plan</i> Dental Office Name: _____ Dental Office Phone Number: _____	<input type="checkbox"/> <b>Delta Dental PPO<sup>SM</sup></b> Delta Dental of California  Dental fee-for-service plan	<input type="checkbox"/> <b>vsp<sup>TM</sup> individual vision plans</b>
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<b>Primary Enrollment Information</b> Name: _____ Address: _____ City, State, Zip: _____ Home Phone: ( ) _____ E-mail Address: _____ Date of Birth: / / <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number: _____	<b>Action Requested:</b> <input type="checkbox"/> New enrollment <input type="checkbox"/> Add dependent <input type="checkbox"/> Remove dependent <input type="checkbox"/> Name change <input type="checkbox"/> Address change <input type="checkbox"/> Social Security Number correction	<input type="checkbox"/> <b>COBRA Enrollment Only</b> <i>I understand that I may be required by the employer to pay for COBRA benefits.</i>  <i>Note: If dependent is enrolling under own Social Security Number, the original enrollee's Social Security Number must be provided.</i> Primary enrollee's SSN: - - / / Qualifying Date: / / Qualifying Reason: _____	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated Do you have dependent children? Yes <input type="checkbox"/> No <input type="checkbox"/> Does your spouse have a dental plan? Yes <input type="checkbox"/> No <input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent children <input type="checkbox"/> If Delta Dental, indicate Group Number _____	<b>Date Employed:</b> / /  <b>Employee Classification:</b> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Certificated <input type="checkbox"/> Classified <input type="checkbox"/> Retired <input type="checkbox"/> COBRA
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<b>Dependent Information:</b> Spouse Name, (Last, First MI) _____ Spouse' Social Security Number: - - / / Date of Birth: / / Marriage/Divorce Date: / / <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>For PMI enrollees only:</b> Code*: _____ Dental Office Name: _____ Phone Number: _____
<b>Children:</b> Name, (Last, First MI) _____ Child Social Security Number - - / / Date of Birth: / / If 19 or older, indicate Full-time student <input type="checkbox"/> Disabled <input type="checkbox"/> Male <input type="checkbox"/> Female _____ <input type="checkbox"/> _____ <input type="checkbox"/> Male <input type="checkbox"/> Female _____ <input type="checkbox"/> _____ <input type="checkbox"/> Male <input type="checkbox"/> Female _____ <input type="checkbox"/> _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Code*: _____ Dental Office Name: _____ Phone Number: _____

*\*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: \_\_\_\_\_