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	

For PMI enrollees only:

Code*:	Dental Office Name:	Phone Number:

Children:

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

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: