VISION? Y OR N

Dual-Choice Enrollment Form

For Delta Dental internal use only
Group/Employer number: _____
Coverage type code: _____
Effective date: _____

Group Name: _____ Group/Division number: _____

For PMI internal use only
Group/Employer number: _____
ID number: _____
Effective date: _____

Please select ONE of the following dental plans:

☐ DELTA DENTAL® Delta Dental of California — Dental fee-for-service plan

OR

☐ PMI DENTAL HEALTH PLAN An Affiliate of Delta Dental of California — **(DeltaCare) Region # _____**

Dental HMO plan
You must select a network dentist for this plan
Dental office name: _____ Office number: _____

Primary Enrollee Information:
Name: _____
Address: _____
_____
City, state & ZIP: _____
Home phone number: (_____)_____
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 (SSN), the original enrollee's social security number must be supplied.
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's SSN	Date of birth	Marriage/Divorce date	M	F
		___/___/___	___/___/___	☐	☐

Child(ren):

Name (Last, First, MI)	Child's SSN	Date of birth	If 19 or older, indicate: Full-time student	Disabled	M	F
		___/___/___	☐	☐	☐	☐
		___/___/___	☐	☐	☐	☐
		___/___/___	☐	☐	☐	☐
		___/___/___	☐	☐	☐	☐

For PMI enrollees only:

Code*	Dental office name (if different)	Dental office number

Code*	Dental office name (if different)	Dental office number

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

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

Enrollee Signature: _____ **Date:** _____