For Delta Dental internal use only

Group/Employer number: _____

Coverage type code: _____

Effective date: _____

Dual-Choice Enrollment Form

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 PPO) DELTA DENTAL® Delta Dental of California

Dental fee-for-service plan

OR

☐ (DeltaCare HMO) PMI DENTAL HEALTH PLAN® An Affiliate of Delta Dental of California

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

Date Employed:

_____ / _____ /_____

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

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

☐ **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 ☐ Domestic Partnership ☐ Divorced ☐ Separated

Do you have dependent children? ☐ Yes ☐ No

Does your spouse have a dental plan? ☐ Yes ☐ No

Who is covered by spouse? ☐ Yourself ☐ Spouse ☐ Dependent children

If Delta Dental, indicate group number: _____

Dependent information:

Spouse/Domestic Partner:

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:** _____