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®

Dental fee-for-service-plan

OR

☐ 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: _____

Martial Status:
☐ Single ☐ Married ☐ Dependent 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, M)	Spouse's SSN	Date of birth	Marriage/Divorce Date	M	F
		__/__/____	__/__/____	☐	☐

Child((ren):

Name (Last, First, M)	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

*Relation 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: _____