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

Dual-Choice Enrollment Form

Group Name: Lodi Association of Realtors
Group/Division number:

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

Please select ONE of the following dental plans:

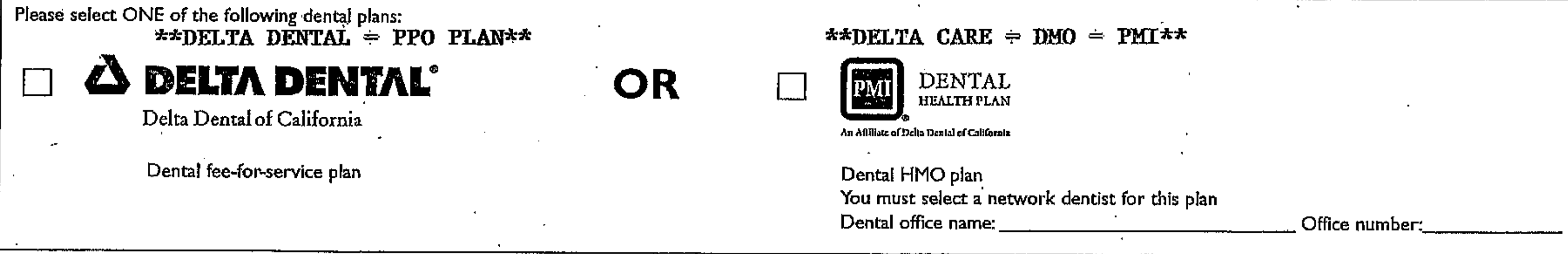
DELTA DENTAL ÷ PPO PLAN

☐ DELTA DENTAL®
Delta Dental of California

Dental fee-for-service plan

OR

DELTA CARE ÷ DMO ÷ PMI

☐ 

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:** ______

Delta 1813 (Rev. 12/04)