

For Delta Dental internal use only

Group/Employer number: _____
Coverage type code: _____
Effective date: _____

Dual-Choice Enrollment Form

Group Name: **Placer County 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 CARE = DMO = PMI****



OR



Delta Dental of California

An Affiliate of Delta Dental of California

Dental fee-for-service plan

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: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female Social security number: _____	Action Requested: <input type="checkbox"/> New enrollment <input type="checkbox"/> Add dependent <input type="checkbox"/> Remove dependent <input type="checkbox"/> Name change <input type="checkbox"/> Address change <input type="checkbox"/> Social security number correction	<input type="checkbox"/> COBRA Enrollment Only <i>I understand that I may be required by the employer to pay for COBRA benefits.</i> 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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated Do you have dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent children If Delta Dental, indicate group number: _____	Date Employed: ____/____/____ Employee Classification: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Certified <input type="checkbox"/> Classified <input type="checkbox"/> Retired <input type="checkbox"/> COBRA
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Dependent information: Spouse: Name (Last, First, MI) _____ Spouse's SSN _____ Date of birth ____/____/____ Marriages/Divorce date ____/____/____ M <input type="checkbox"/> F <input type="checkbox"/> Child(ren): Name (Last, First, MI) _____ Child's SSN _____ Date of birth ____/____/____ If 19 or older, indicate: Disabled <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Full-time student <input type="checkbox"/> Disabled <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>	Relationship Codes: Spouse - SP Domestic Partner - DP Child - CH Child of DP - CD Other Adult - OA Other Child - OC
For PMI enrollees only: Code* _____ Dental office name (if different) _____ Code* _____ Dental office name (if different) _____ Code* _____ Dental office name (if different) _____ Code* _____ Dental office name (if different) _____	Dental office number _____ Dental office number _____ Dental office number _____ Dental office number _____

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: _____