

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

Dual-Choice Enrollment Form

Group Name: **Sacramento Association of Realtors**
 Group/Division number: _____

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 ID number: _____
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Please select ONE of the following dental plans:
****DELTA DENTAL = PPO PLAN****



Delta Dental of California
 Dental fee-for-service plan

****DELTA CARE = DMO = PNT****



An Affiliate of Delta Dental of California
 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:	Spouse's SSN	Date of birth	Marriage/Divorce date	M	F	Code*	Dental office name (if different)	Dental office number
Name (Last, First, MI)		____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>			
Child(ren):	Child's SSN	Date of birth	If 19 or older, indicate:	M	F	Code*	Dental office name (if different)	Dental office number
Name (Last, First, MI)		____/____/____	Full-time <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		____/____/____		<input type="checkbox"/>	<input type="checkbox"/>			
		____/____/____		<input type="checkbox"/>	<input type="checkbox"/>			
		____/____/____		<input type="checkbox"/>	<input type="checkbox"/>			

*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: _____