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® Delta Dental of California

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:
____

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:** ____________

Delta 1813 (Rev. 12/04)