SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | Email info@scptac.org | www.scptac.org

Dental Benefit Enrollment Form

OPEN ENROLLMENT DEADLINE: November 30, 2024

NOTICE: All eligible participants interested in updating dental coverage must return a *Dental Enrollment Form* to the Fund Office via mail, fax or email at the address above by November 30, 2024.

If you do not return a *Dental Enrollment Form* by the deadline, your dental coverage will remain unchanged.

PART 1—PARTICIPANT INFORMATION

Participant Name (First, Middle Initial, Last) _____

Participant Social Security Number (Only last 4 required) or Medical ID Number (T-number) _____

Address _____

City, State, ZIP Code _____

Date of Birth _____ Phone Number _____ Email Address _____

(You must provide a U.S. address in order to qualify for **DeltaCare USA**.)

PART 2—DENTAL BENEFIT ELECTION (Check One)

I elect the following dental benefit option for myself and eligible dependents effective January 1, 2025:

A ☐ **OPTION 1 – DELTACARE USA DENTAL HMO PLAN**
SIX-DIGIT DELTACARE USA FACILITY CODE * (Optional) _____

B ☐ **OPTION 2 – METLIFE PPO PLAN**

PART 3—PARTICIPANT AGREEMENT AND SIGNATURE

I have read and understand the material provided describing my dental benefit options. I have asked any questions to the Southern California Pipe Trades Administrative Corporation, DeltaCare USA or MetLife and have received acceptable answers.

I understand that if I do not return a *Dental Enrollment Form* my dental coverage will remain unchanged.

I understand that I will not be permitted to change my dental plan again until the next open enrollment period, which is scheduled late in 2025 for changes effective January 1, 2026.

* I understand that if I do not enter a Facility Code in Part 2, DeltaCare USA will assign me to a primary dentist based on the first in-network dental provider that files a claim. Thereafter, I will be permitted to change my dentist by contacting DeltaCare USA.

X _____ _____
Participant Signature Date