



Dental Benefit Enrollment Form

OPEN ENROLLMENT DEADLINE: November 30, 2022

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, 2022.

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, 2023:

- A** **OPTION 1 – DELTACARE USA DENTAL HMO PLAN**
 SIX-DIGIT DELTACARE USA FACILITY CODE * (Optional) _____
- B** **OPTION 2 – DELTA DENTAL 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 or Delta Dental 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 2023 for changes effective January 1, 2024.

* I understand that if I do not enter a Facility Code in Part 2, DeltaCare USA will initially assign me to a primary dentist based on my home zip code. I will be permitted to change my dentist by contacting DeltaCare USA after I have enrolled.

X _____
Participant Signature

Date