DGA-PRODUCER PENSION & HEALTH

DENTAL PLAN ELECTION FORM

If you are a California resident you have two dental coverage options:

1) **Delta Dental PPO Plan**

   This is fee-for-service dental plan. **This is the default plan unless you elect the option below.**

2) **DeltaCare Dental HMO Plan**

   This is an HMO dental plan. To choose this option, initial the statement below and return this form before the end of your open enrollment period by mail to **DGA–Producer Health Plan, 5055 Wilshire Blvd, Ste. 600, Los Angeles, CA 90036** or fax it to **(323) 866-2399**.

   _____ I elect to participate in the **DeltaCare Dental HMO Plan**. I understand that I may only change my dental election annually during the 30-day open enrollment period at the beginning of my benefit period.

Upon receiving your completed form, the Health Plan will send you a separate DeltaCare Dental HMO enrollment form that must be completed and returned immediately to the Health Plan office before coverage can be effective.

Name: _____

Health Plan ID Number: _____

Signature: X _____

Must be signed by the participant

Date: _____