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: __________________________________________________________________