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

DEADLINE: NO LATER THAN 60 DAYS FROM INITIAL ELIGIBILITY DATE

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

If you do not return a Dental Enrollment Form, you and your family will not have dental coverage.

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:

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 or Delta Dental/MetLife and have received acceptable answers.

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

I understand that if a form is not received within 60 days of my initial eligibility date, dental coverage will be effective the first of the following month after my Dental Enrollment Form is received.

Once enrolled, I understand that I will not be permitted to change my dental plan again until the next open enrollment period.

* 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.

X _____ _____
Participant Signature Date