Bay East Association of Realtors®

DENTAL

IMPORTANT INSTRUCTIONS:

Please complete all information requested and write your Bay East Association of Realtors® member number at the top of the application.

Please type or write in ink.

Include payment for two month's premium payable to "ARBA".

Send the original application and check to:

AUSTIN & AUSTIN INSURANCE SERVICES, INC.
5890 STONERIDGE DRIVE #209
PLEASANTON, CA 94588

Please call our office to confirm receipt and with any questions,

1-800-987-1475

COVERAGE DOES NOT BECOME EFFECTIVE UNDER ANY CIRCUMSTANCES UNTIL AND UNLESS THE APPLICATION HAS BEEN APPROVED BY THE DENTAL PLAN ITSELF

AUSTIN & AUSTIN
INSURANCE SERVICES, INCORPORATED

CA Lic #0C10853

For Delta Dental internal use only
Group/Employer number: ____
Coverage type code: ____
Effective date: ____

Dual-Choice Enrollment Form

Group Name:
Group/Division number:

For PMI internal use only
Group/Employer number: ____
ID number: ____
Effective date: ____

Please select ONE of the following dental plans:

☐

Dental fee-for-service plan

OR

☐

Dental HMO plan
You must select a network dentist for this plan
Dental office name: ____ Office number: ____

Primary Enrollee Information:
Name: ____
Address: ____
City, state & ZIP: ____
Home phone number: (____) ____
E-mail address: ____
Date of birth: ___/___/___
☐ Male ☐ Female
Social security number: ____

Action Requested:
☐ New enrollment
☐ Add dependent
☐ Remove dependent
☐ Name change
☐ Address change
☐ Social security number correction

☐ **COBRA Enrollment Only**
I understand that I may be required by the employer to pay for COBRA benefits.
Note: If dependent is enrolling under own social security number (SSN), the original enrollee's social security number must be supplied.
Primary enrollee's SSN: ____
Qualifying date: ___/___/___
Qualifying reason: ____

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Separated
Do you have dependent children?
☐ Yes ☐ No
Does your spouse have a dental plan?
☐ Yes ☐ No
☐ Yourself
☐ Spouse
☐ Dependent children
If Delta Dental, indicate group number: ____

Date Employed:
___/___/___
Employee Classification:
☐ Full-time
☐ Part-time
☐ Salaried
☐ Hourly
☐ Certificated
☐ Classified
☐ Retired
☐ COBRA

Dependent information:

Spouse:

Name (Last, First, MI)	Spouse's SSN	Date of birth	Marriage/Divorce date	M	F
____	____	___/___/___	___/___/___	☐	☐

Child(ren):

Name (Last, First, MI)	Child's SSN	Date of birth	If 19 or older, indicate: Full-time student	Disabled	M	F
____	____	___/___/___	☐	☐	☐	☐
____	____	___/___/___	☐	☐	☐	☐
____	____	___/___/___	☐	☐	☐	☐
____	____	___/___/___	☐	☐	☐	☐

For PMI enrollees only:

Code*	Dental office name (if different)	Dental office number
____	____	____

Code*	Dental office name (if different)	Dental office number
____	____	____
____	____	____
____	____	____
____	____	____

**Relationship Codes: Spouse – SP Domestic Partner – DP Child – CH Child of DP – CD Other Adult – OA Other Child – OC*

I understand that I may be required by the employer to pay for these benefits and those for my dependents. I agree to continue membership in the program selected above during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature: ____ **Date:** ____

Delta 1813 (Rev. 12/04)