



For District Use Only Group Number
Eff. Date

DELTA DENTAL DESIGNATION FORM

1. DISTRICT NAME:	DISTRICT ID #:

2. PERSONAL INFORMATION:

<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	NAME:			
	Last	First	MI	
Street Address	City	State	Zip	Phone ()
Social Security Number	Birthdate			

3. SELECT COVERAGE:

- DELTA PREMIER INCENTIVE PLAN
- DELTA PPO (DPO) PLAN

By choosing the PPO/DPO Plan I understand that I am responsible for a greater portion of my dental costs when I use a non-preferred provider. I realize that I cannot change to the Delta Traditional Incentive Plan until a subsequent Open Enrollment period with an October 1 effective date. I also understand that if I choose to change to the Incentive Plan during an Open Enrollment, my benefits will start at 70%.

4. SIGNATURE:

Subscriber's Signature	Date
------------------------	------

For district use only. Please do not forward to SISC.