



SISC III
SELF-INSURED SCHOOLS of CALIFORNIA

For District Use Only
Group Number
Eff. Date

DELTA DENTAL DESIGNATION FORM

1. DISTRICT NAME:

DISTRICT ID #:

2. PERSONAL INFORMATION:

- MALE
- FEMALE

NAME:

_____ Last

_____ First

_____ MI

Street Address

City

State

Zip

Phone

()

Social Security Number

Birthdate

3. SELECT COVERAGE:

DELTA TRADITIONAL INCENTIVE PLAN

DELTA PREFERRED OPTION (DPO)

By choosing the 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 generally held in September or October. 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