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

OPEN ENROLLMENT DEADLINE: November 30, 2023

NOTICE: All eligible participants interested in updating dental coverage must return a *Dental Enrollment Form* to the Fund Office via mail, fax or email at the address above by November 30, 2023.

If you do not return a *Dental Enrollment Form* by the deadline, your dental coverage will remain unchanged. Please note, if you are currently enrolled in the Delta Dental PPO Plan, the MetLife Dental PPO Plan will replace your current Plan effective January 1, 2024.

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 effective January 1, 2024:

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 DeltaCare USA/MetLife and have received acceptable answers.

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

I understand that I will not be permitted to change my dental plan again until the next open enrollment period, which is scheduled late in 2024 for changes effective January 1, 2025.

* 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 DeltaCare USA.

X _____ _____
Participant Signature Date