



SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND

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Dental Benefit Enrollment Form

OPEN ENROLLMENT DEADLINE: November 30, 2026

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, 2026.

If you do not return a *Dental Enrollment Form* by the deadline, your dental coverage will remain unchanged.

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, 2027:

- 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, **DeltaCare USA** or **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 2027 for changes effective January 1, 2028.

* 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