



PSEA

VOLUNTARY ENROLLMENT GROUP DENTAL PROGRAM

DeltaCare USA

Delta PPO

DeltaPremier B

Office Use Only

Group No. _____

Contract Type _____

Effective Date _____

PLEASE PRINT

Your Full Name _____
Last First Middle

Mailing Address _____
Street Address City State & Zip

Date of Birth ____/____/____ Male Female Phone _____ Social Security No: _____
(Area Code)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Spouse _____	Born ____/____/____	Sex _____
Child _____	Born ____/____/____	Sex _____
Child _____	Born ____/____/____	Sex _____
Child _____	Born ____/____/____	Sex _____

DeltaCare USA Only: Please indicate dental office of choice _____ Office Number _____

I understand that I will be required to pay for these benefits. I agree to continue membership in this program for a minimum of 12 months and comply with the terms of the group contract.

Signature of Applicant: _____ Date ____/____/____

VISA / MC # _____ 3 digit sec _____ Exp: ____/____/____

