



**PSEA**  
VOLUNTARY ENROLLMENT  
GROUP DENTAL PROGRAM

For Office Use Only	
Effective Date	_____
Group No.	_____
Contract Type	_____

PLEASE PRINT

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State & Zip \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Male  Female  Phone (\_\_\_\_) \_\_\_\_\_ SSN: \_\_\_\_\_

**PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF**

Spouse _____	Born ___/___/___	Sex _____
Child _____	Born ___/___/___	Sex _____
Child _____	Born ___/___/___	Sex _____
Child _____	Born ___/___/___	Sex _____

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:Date \_\_\_/\_\_\_/\_\_\_

If you have not yet retired: Expected Retirement Date \_\_\_/\_\_\_/\_\_\_ Home email address \_\_\_\_\_

Please return to PSEA, Suite 240, 1390 Willow Pass Rd, Concord, CA 94520



**PACIFIC SERVICE EMPLOYEES ASSOCIATION**  
GUARDIAN RATE SHEET  
for Retiree & Associate Members of PSEA



<b>RATES</b>	<b>2023 QUARTERLY PRICING</b>
Member only	\$ 132.00
Member + 1 Dependent	\$ 246.00
Member + 2 or more Dependents	\$ 378.00

**\*\*Please note:** Guardian coverage is to be paid quarterly. Please remit the first quarter payment, credit card or check made payable to "PSEA", along with your enrollment application.