



PSEA
VOLUNTARY ENROLLMENT
GROUP DENTAL PROGRAM

Delta PPO ☐
Delta Premier B ☐
DeltaCare USA CA ☐
DeltaCare USA NV ☐

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
DELTA RATE SHEET
for Retiree & Associate Members of PSEA



RATES: Delta PPO		2027 QUARTERLY PRICING
Member only		\$198.00
Member + 1 Dependent		\$384.00
Member + 2 or more Dependents		\$681.00

RATES: Delta Premier Table Plan		2027 QUARTERLY PRICING
Member only		\$168.00
Member + 1 Dependent		\$300.00
Member + 2 or more Dependents		\$438.00

RATES: DeltaCare USA HMO - CA & NV only		2027 QUARTERLY PRICING
Member only		\$141.00
Member + 1 Dependent		\$234.00
Member + 2 or more Dependents		\$432.00

****Please note:** Delta 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.