Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: **(818) 987-5000** Fax: **8187769865**

Step 2

SELECT THE TYPE OF BILLING YOU WANT – annual.

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana, CA 91356

Please make your check payable to: DeltaCare

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at: (818) 987-5000

Thank you for choosing...

DELTACARE®

DELTACARE®

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703

Check One

☐ New Enrollment
☐ Name Change]

[Indicate effective date of change:
*(Does not pertain to facility change)

(Month) (Day) (Year)]

DeltaCare SENIOR DENTAL PROGRAM
ENROLLMENT AND PAYMENT AUTHORIZATION FORM

Applicant Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last) (First) (M.I.)

Mailing Address: (Street Address)

(City) (State) (Zip Code)

Date of Birth: (Month) (Day) (Year)

Male ☐ Female ☐

Home Phone #: ( ) —

Identification #: — —

Contract Facility Name:

Contract Facility #:

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that PMI's ratio of health care expenses to premiums received for the last calendar year, with respect to the DeltaCare Senior Dental HMO Program, was **61.39%**.

[Return form to **Oleg Skurskiy** . **18375 Ventura Blvd. # 226** **Tarzana, CA 91356**

[ ] Signature of Applicant:

Date:

CA591

DELTACARE®

Please complete both sides PLEASE PRINT

PROGRAM COST

Choose one based on the information on the reverse side.

☐ Enrollee Premium	$135.00
☐ One-time Enrollment Fee	$ 15.00
TOTAL	$150.00

This Enrollment and Payment Authorization Form and your check or money order, if applicable, must be received by the 15th day of the month for your coverage to be effective on the first day of the following month.

I wish to enroll in the DeltaCare Senior Dental HMO Program. I acknowledge that I have read the Disclosure Form/Contract and understand that coverage under the Program is subject to the terms as described in the Disclosure Form/Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of PMI, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the PMI provider agreements or local, state or federal laws. This authorization is valid for the duration of coverage.

CA591

PAYMENT OPTION (choose only one)

PAYMENT OPTIONS

[☐ CHECK/MONEY ORDER PAYMENT OPTION

Please make check or money order payable to PMI. You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of care.]

☐ CREDIT CARD PAYMENT OPTION

☐ VISA ☐ MASTERCARD

CARD# _____

EXPIRATION DATE _____

NAME AS IT APPEARS ON THE CARD

_____

[SIGNATURE _____]

DATE _____

[By signing above you authorize PMI to charge your credit card account for the cost of the DeltaCare Program.]

Note: Any credit card refunds under the Program may be made by check or credit card.

(ED 01/02)