



SISC III
SELF-INSURED SCHOOLS of CALIFORNIA

For District Use Only
Group Number
Eff. Date

DELTA DENTAL DESIGNATION FORM

1. DISTRICT NAME:	DISTRICT ID #:
Wilsona School District	65151

2. PERSONAL INFORMATION:	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	NAME: _____
	<div style="display: flex; justify-content: space-between;"> _____ Last _____ First _____ MI </div>

Street Address	City	State	Zip	Phone ()
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Social Security Number	Birthdate
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3. SELECT COVERAGE: <input type="checkbox"/> DELTA PPO INCENTIVE (aka Traditional or Premier)-DD2000 Starts at 70%. <input type="checkbox"/> DELTA PREFERRED OPTION (DPO/PPO) PLAN-DPO/PPO 3000 By choosing the DPO Plan I understand that I am responsible for a greater portion of my dental costs when I use a non-preferred provider. I realize that I cannot change to the Delta PPO Incentive Plan- (aka Traditional) until a subsequent Open Enrollment period generally held in August or September. I also understand that if I choose to change to the Incentive Plan during an Open Enrollment, my benefits will start at 70% .

4. SIGNATURE:	
_____	_____
Subscriber's Signature	Date