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: **(310) 827-7286** Fax: **310-827-0256**

Step 2

SELECT THE TYPE OF BILLING YOU WANT – annual.

Step 3

SEND THE COMPLETED APPLICATION TO:

Barricks Insurance Services
13900 NW Passage #302
Marina Del Rey, CA 90292

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: (310) 827-7286

Thank you for choosing...

DELTACARE®

DeltaCare INDIVIDUAL/FAMILY DENTAL HMO PROGRAM
ENROLLMENT AND PAYMENT AUTHORIZATION FORM

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

Check One

- ❑ New Enrollment
- ❑ Name Change
- ❑ Facility Change*
- ❑ Address Change
- ❑ Add Dependent
- ❑ Remove Dependent

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

(Month) (Day) (Year)

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 #:

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Male/ Female (Check One) M	F	Date of Birth (Month) (Day) (Year)
		❑	❑	
		❑	❑	
		❑	❑	
		❑	❑	
		❑	❑	
		❑	❑	
		❑	❑	

*Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:

Spouse - SP Domestic Partner - DP Child - CH Other Child - OC

I understand that, if I have indicated on this form that coverage under the Program is to be provided only for the dependent child named above, I am responsible for payment of required annual Premium and compliance with all of the provisions and conditions of the Disclosure Form/ Contract.

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 Individual/Family Dental HMO Program, was 56.65%

Barricks Insurance Services

13900 NW Passage #302

Marina Del Rey, CA 90292

Agent Number: **4378**

Return form to: **13900 NW Passage #302** **Marina Del Rey, CA 90292**

Signature of Applicant: Date:

CA596

DELTACARE®

PLEASE PRINT

Please complete both forms

PROGRAM COST AND PAYMENT OPTION (choose only one)

Choose one, and include the appropriate cost, based on the information on the opposite side.

☐	Enrollee annual Premium	$ 97.00
☐	Enrollee plus one dependent annual Premium	$155.00
☐	Enrollee plus two or more dependents annual Premium	$225.00
☐	One-time Enrollment Fee	$ 15.00
	TOTAL	$_____

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 Individual/Family 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.

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 coverage.

☐ 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.

Signature: _____ Date: _____

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