SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

For District Use Only Group Number
Eff. Date

DELTA DENTAL DESIGNATION FORM

1. DISTRICT NAME:	DISTRICT ID #:

2. PERSONAL INFORMATION:

[ ] MALE
[ ] FEMALE

NAME: Last | First | MI

Street Address	City	State	Zip	Phone
				( )

Social Security Number	Birthdate

3. SELECT COVERAGE:

[ ] DELTA PREMIER INCENTIVE PLAN

[ ] DELTA PPO (DPO) PLAN

By choosing the PPO/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 Traditional Incentive Plan until a subsequent Open Enrollment period with an October 1 effective date. 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

For district use only. Please do not forward to SISC.