



VOLUNTARY "Workplace" ENROLLMENT FORM

I am enrolling for: Dental Vision Both Dental & Vision

A. All Employees Must Complete This Section	Name of Firm Where Employed		Occupation		Date of Full-Time Employment		
	Employee Name Last		First		Middle		Phone Number (Home)
							()
	Home Address			City		State	
	Social Security Number	Date of Birth	Age	Gender	Marital Status		No. of Eligible Dependents
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Not married		
B. Complete this section to select a Dental Provider	View a list of DeltaCare dentists at www.Deltadentalca.org/directory click on DeltaCare Dentist						
	View a list of Davis Vision providers at www.multibenefitplans.com you may go to any Davis Vision provider shown on the website.						
	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="display: flex; justify-content: space-between;"> Please indicate Dental office selected Dental office number from directory </div>						
C. Complete this section if you are covering dependents	DEPENDENT INFORMATION						
	Are you covering your dependents? <input type="checkbox"/> Yes (If yes, please complete the information below)						
	<input type="checkbox"/> No (If no, please complete the Waiver/Declination of Coverage Form)						
	Dependent Name		Relationship to You	Sex	Date of Birth		Social Security Number
	Last First Middle				Mo	Day	Year
	1.						
	2.						
3.							
4.							
5.							
<p>I certify that my date of birth, date of full-time employment and other information on this form is correct and that I am working at the employer's place of business in a full-time capacity of at least 24 hours per week or as mirrors our health plan eligibility. I agree to continue my participation in the program while coverage is in force. I understand that, if enrolled in the DeltaCare Dental plan, you may assign me to a dental provider if I have not indicated my selection above.</p>							
Your Signature in ink				Date: Month Day Year			
FOR OFFICE USE ONLY	Process Date	Processed By:	Effective Date	Dental Group #	Dental Code		

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