# DENTAL OPTION FORM

Send completed form to: Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119

***Please enroll me in the Dental Plan Option checked below.***
***I understand that my choice will apply to me and to all my eligible dependents:***

❑ Option 1 - Indemnity Dental Plan (Delta Dental)

**Note:** *If new employee, you may not choose Option 1 unless you qualify under one of the exceptions explained on the back of this form.*

❑ I am a new employee, but I qualify to choose Option 1 - Indemnity Dental Plan under the following exception.

Exception Number: [ ] See side 2 for list of exceptions.

❑ Option 2 - Consumer Dental

❑ Option 3 - PacificDental Benefits (PDB)

*Formerly Pacific Union Dental (PUD)*

**Note:** *If Option 3, please enter your PDB dental office and phone numbers:*

| PDB Office Number | PDB Office Phone |
|---|---|
| | ( ) |

| Employee's Name (Last, First, Middle Initial) *Please Print* | | Social Security Number | | Birth Date (Month-Day-Year) |
|---|---|---|---|---|
| Spouse's Name (Last, First, Middle Initial) *Please Print* | | Social Security Number | | Birth Date (Month-Day-Year) |
| Address *Please Print* | | City | State | Zip Code |
| Work Phone ( ) | Home Phone ( ) | | | |
| Your Employer | | Date Hired (Month-Day-Year) | Local Union Number | |

***ELIGIBLE DEPENDENT CHILDREN*** (as listed on my TBT *Enrollment Form*)
Please list additional eligible dependents on the back.

| Dependent's Name (Last, First, Middle Initial) *Please Print* | Social Security Number | Birth Date (Month-Day-Year) |
|---|---|---|
| Dependent's Name (Last, First, Middle Initial) *Please Print* | Social Security Number | Birth Date (Month-Day-Year) |
| Dependent's Name (Last, First, Middle Initial) *Please Print* | Social Security Number | Birth Date (Month-Day-Year) |
| Dependent's Name (Last, First, Middle Initial) *Please Print* | Social Security Number | Birth Date (Month-Day-Year) |

| Employee's Signature | Date (Month-Day-Year) |
|---|---|
| | |

***Note:*** You may change dental plan options *only* during the annual Open Enrollment period.
If you have questions, please call the Plan Administration Office at (510) 796-4676 or (800) 533-0119.

***Return this form to: Teamsters Benefit Trust, P.O. Box 5820, Fremont, CA 94537-5820***
A pre-addressed envelope is enclosed.

# DENTAL OPTION FORM *(Continued)*

### *If You are a Newly Hired Employee (with a Currently Participating Employer)*

The Indemnity Dental option is not available to you until the second Open Enrollment after your initial hire date *unless you meet one of the exceptions listed below*.

Until then, you may enroll in one of the prepaid dental options (Option 2 or Option 3) listed on this form. Brochures describing the Consumer Dental and PacificDental Benefits options are enclosed. If you need more information about Option 1—the Indemnity Dental option, see the *Guide to Your Benefits* and *Summary of Coverage*. The *Comparison of Dental Benefits* also helps you compare differences between available dental options. If you have questions about your eligibility or benefits, contact the Plan Administration Office at (510) 796-4676 or (800) 533-0119.

### *EXCEPTIONS*

You may enroll in Delta Dental as a newly hired employee *only* if you meet *one of the following exceptions*. Be sure to list the exception number on this *Dental Option Form* or your enrollment will be delayed:

1. You live more than 30 miles from the nearest Consumer Dental or PacificDental Benefits office which is accepting new patients, or
2. All covered persons in your family do not live in the same household and one or more covered family members lives more than 30 miles from a Consumer Dental or PacificDental Benefits office which is accepting new patients, or
3. You are continuing coverage which you already had with Delta Dental for at least 12 months before your TBT hire date. (Provide name and phone number of dentist below.) Either you or one of your eligible dependents must have received dental services twice in the past 12 months, or
4. You were previously covered under TBT Dental Option 1 within the past 12 months, or
5. You are exempted from the TBT new employee waiting period requirements and enclose a written copy of this exemption, or
6. You are part of a new employer group which has just joined the TBT plan.

Exception Number: ______

**Please provide additional details:**

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