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 - *Bright Now!* Dental

❑ Option 3 - UHC Select Managed Care

Office Number	Office Phone ( )

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

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 your Open Enrollment period.
If you have questions, please call the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119.

SEND the completed form in one of these ways:
- Fax to TBT at (510) 795-9237
- E-mail to enroll@lipmantpa.com
- Mail or bring to: TBT Plan Administration Office, 39420 Liberty Street, Suite 260, Fremont CA 94538

All completed forms must be sent to TBT. ***Do not send anything directly to an HMO or dental provider!***

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 one year following your initial hire date (when your open enrollment period starts) unless you meet one of the exceptions below. See Open Enrollment rules in the *Guide to Your Benefits*.

Until then, you may enroll in one of the prepaid dental options (Option 2 or Option 3) listed on this form. Brochures describing the *Bright Now!* Dental and UHC Select Managed Care 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 TBT 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 *Bright Now!* Dental or UHC Select Managed Care 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 *Bright Now!* Dental or UHC Select Managed Care office which is accepting new patients, or
3. You have received treatment from a **Delta Dental dentist** within the past twelve months (and can, upon request, provide an invoice for such treatment) and wish to continue receiving treatment from that dentist while enrolled in your TBT plan, 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: