CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
4160 Dublin Blvd, Suite 400
Dublin, CA 94568
Telephone: (707) 864-3300 or (888) 245-5005
E-Mail Address: nccmenrollment@hsba.com

FUND OFFICE USE ONLY
EFF. DATE:
HCID: **HA**
ELIGIBILITY CODE/GROUP NO.:

ACTIVE & RETIRED PLANS DENTAL ENROLLMENT FORM

PARTICIPANT INFORMATION (Please print or type in black ink only)

SOCIAL SECURITY NUMBER	NAME: FIRST MIDDLE LAST				
RESIDENCE ADDRESS (not Post Office Box)	CITY			STATE	ZIP CODE
TELEPHONE NO. ( )	LOCAL UNION	DATE OF BIRTH MONTH	DAY	YEAR	GENDER ☐ MALE ☐ FEMALE / MARITAL STATUS ☐ SINGLE ☐ MARRIED

DENTAL PLAN OPTIONS

IMPORTANT: You and your Dependents must be enrolled in the same Dental Plan. Check only one box.

☐ **Delta Dental.** You may seek dental care from any dentist but, your out-of-pocket expense is lower if you use a participating Delta Dental dentist.

☐ **DeltaCare USA**. You must select a Dental Office from Delta Care Participating Dental Offices Directory:

Name of Dental Office: _____ Facility No.: _____

☐ **UnitedHealthcare Dental.** You must select a dentist or dental group from UnitedHealthcare Dental Provider Directory:

Name of Dentist: _____ Dentist No.: _____

DEPENDENT INFORMATION (List all eligible dependents to be enrolled. Use back page if more space needed.)

FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM EMPLOYEE)	DATE OF BIRTH MO / DY / YR	DEPENDENT RELATIONSHIP	FUND OFFICE USE ONLY
1.		SPOUSE	
2.		☐SON ☐DAUGHTER	☐STUDENT
3.		☐SON ☐DAUGHTER	☐STUDENT
4.		☐SON ☐DAUGHTER	☐STUDENT
5.		☐SON ☐DAUGHTER	☐STUDENT

I understand that once I have selected a Plan, I cannot change to another Plan until the next Open Enrollment. I agree to be bound by the benefits, deductions, co-payments, exclusions and other terms of the Plan group agreement. **Your application will not be accepted without your signature below. Please return this Enrollment Form to the Fund Office.**

Important: If you enroll in DeltaCare USA or UnitedHealthcare Dental, any dispute that may arise between you and the Dental Plan will be subject to binding arbitration.

Date:_____ Participant's Signature:_____

FUND OFFICE USE ONLY (Please do not write in this space)

☐ NEW EMPLOYEE ☐ OPEN ENROLLMENT

☐ COBRA - DATE OF QUALIFYING EVENT_____

REMARKS:

DATE:_____ BY:_____