PacificSource HEALTH PLANS

**Graduate Teaching Fellows Federation**

# Dental Plan Selection Form

Complete Section 1 to select a dental plan. If you select the Dental Advantage Essentials plan, then complete Section 2 to select a Primary Care Dentist (PCD)**. This form is <u>not</u> to newly add employees or family members; if you or family members are newly enrolling with PacificSource, please complete an Enrollment Application instead.**

*Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes.*

| **Section 1 – Select a Dental Plan (Required)** | | | |
|---|---|---|---|
| Employee Name | Member ID No. (see ID card) | Employer/Group Name<br>**Graduate Teaching Fellows Federation** | Employer/Group No.<br>**G0021003** |
| Name of Dental Plan Design<br>☐ Dental Advantage **Essentials**(HMO, 6 clinics, no cap)<br>☐ Dental Advantage **Plus** (PPO, any DDS, $1000 cap) | Student ID | Email Address | |

**Section 2 – Select a PCD (For Dental Advantage Essentials Plan Only)**

[1] Ethnicity/Race Code: AIAN-American Indian/Alaska Native, A-Asian, B-Black/African American, H-Hispanic/Latino, N-Native Hawaiian/Other Pacific Islander, W-White/Caucasian

| *Name* | *Social Security Number–**Required** Section 111 of Public Law 110-173* | *Ethnicity / Race[1] **Optional*** | *Full Name of Primary Care Dentist (PCD)* | *PCD's Patient Currently?* |
|---|---|---|---|---|
| Employee | | | | ☐ Yes ☐ No |
| Spouse or Domestic Partner | | | | ☐ Yes ☐ No |
| Dependent Child | | | | ☐ Yes ☐ No |
| Dependent Child | | | | ☐ Yes ☐ No |
| Dependent Child | | | | ☐ Yes ☐ No |
| Dependent Child | | | | ☐ Yes ☐ No |
| Dependent Child | | | | ☐ Yes ☐ No |

I affirm that the answers given in this application are complete and correct. I, the applicant authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract.

Employee Signature:_____ Date:_____