

 **DeltaCare** for Individuals and Families Online Enrollment

Enrollment and Payment Authorization Form

Broker Number (if applicable):

Tony Canzone Insurance Agency

This form uses JavaScript. We recommend a browser such as [Internet Explorer 4.0](#) or newer OR [Netscape Navigator 4.0](#) or newer.

Plan Number:**CAA52**

Group Number:

00116-0002

PMI must receive the enrollment materials by the 21st day of the month for coverage to be effective the first day of the following month. If PMI receives the enrollment materials after the 21st day of the month, coverage will become effective the first day of the second month.

ANNUAL PREMIUM

Annual premiums are as follows:

Enrollee	\$97.00
Enrollee plus one dependent	\$155.00
Enrollee plus two or more dependents	\$225.00
Onetime Enrollment Fee	\$15.00

Fields noted with an asterisk (*) are required.

INDIVIDUAL PERSONAL INFORMATION

First Name* Initial
 Last Name*
 ID#/SSN *
 Date of Birth* / / (mm/dd/yyyy)
 Gender*
 Address*

3. Child:

First _____ Gender _____
Last _____
Date of Birth: / / (mm/dd/yyyy)

4. Child:

First _____ Gender _____
Last _____
Date of Birth: / / (mm/dd/yyyy)

5. Child:

First _____ Gender _____
Last _____
Date of Birth: / / (mm/dd/yyyy)

6. Child:

First _____ Gender _____
Last _____
Date of Birth: / / (mm/dd/yyyy)

I understand that, if I have indicated on this form that coverage under the Program is to be provided only for the dependent child named above, I am responsible for payment of required Annual Premiums and compliance with all of the provisions and conditions of the Disclosure Form/Contract.

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that PMI's ratio of health care expenses to premiums received for the last calendar year, with respect to the DeltaCare Individual/Family Dental HMO Program, was 54.4%.

FORM OF PAYMENT

Credit Card*

Card Number*

Expiration*

NOTE: By entering the information above, you are authorizing PMI to charge your credit card for the premium amount. Any credit card refunds under the Program may be made by check or credit card.

You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of care.

I wish to enroll in the DeltaCare Individual/Family Dental HMO Program. I ACKNOWLEDGE THAT I HAVE READ THE [DISCLOSURE FORM/CONTRACT](#) and understand that coverage under the Program is subject to the terms as described in the Disclosure Form/Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of PMI, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the PMI provider agreements or local, state or federal laws. This authorization is valid for the duration of coverage.

Click here to acknowledge you have read the above statement.

It is required that you have a printout of the Disclosure Form/Contract. Please select one of the options below:

I have downloaded and printed a copy from the web site. [Click here to download.](#)

I would like to have a copy mailed to the address I entered on this form.

Date: **1 / 26 / 2006**

Note: If you prefer to send this by mail, print this form and send it completed with credit card information or a check or money order made payable to PMI :

PMI

Dept. 0170
Los Angeles, CA 90084-0170

Please sign and date below if you mail this with credit card information:

Signature _____ Date _____