LABORERS FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA
5672 Stonebridge Drive, Suite 100, Pleasanton, CA 94588
Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530
E-Mail Address: customerservice@lfao.org
Website: http://www.lfao.org

FUND OFFICE USE ONLY (610)
EFF. DATE:
HCID: **LA**
ELIGIBILITY CODE/GROUP NO.:

ACTIVE PLAN AND SPECIAL PLAN DENTAL ENROLLMENT FORM

EMPLOYEE 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.

☐ **Anthem Blue Cross Dental Complete.** You may seek dental care from any In-Network or Out-of-Network dentist but, your out-of-pocket expense is lower if you use a participating dentist.

☐ **DeltaCare USA**. You must select a dental office from DeltaCare USA's participating dental offices directory:

Name of Dental Office: _____ Facility No.: _____

☐ **Bright Now!/Newport Dental.** You may seek dental care from any Bright Now! office locations.

☐ **UnitedHealthcare Dental.** You must select a dentist or dental group from UnitedHealthcare's 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
1.		SPOUSE
2.		☐SON ☐DAUGHTER
3.		☐SON ☐DAUGHTER
4.		☐SON ☐DAUGHTER

I understand that once I have selected a Plan, I cannot change to another Plan until the next open enrollment (effective March 1). I agree to be bound by the benefits, deductions, copayments, exclusions and other terms of the Plan group agreement. **Your application will not be accepted without your signature below. Please return this form to the Fund Office.**

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

Date:_____ Employee'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:_____

Revised 10/05/2021