Dental Plan Selection Form

CUESTA COLLEGE INSURANCE/BENEFITS - DENTAL OPEN ENROLLMENT PLAN SELECTION FORM

Please designate your selection by checking the box next to your choice and initialing on the line next to the box.

Print Your Name Clearly	*Signature*	*Banner ID/ Last 4 of SSN*	*Date*

	Single	2-Party	Family	Check Selection and Initial
Dental Coverage is a two year commitment				
Delta Dental Plan A - Group #6736-0001 Deductible $50 Individual / $150 Family Annual Maximum Allowance $1,400 (PPO) $500 Orthodontics Annual Maximum (Adult/Children)	**$53.83**	**$95.72**	**$138.25**	☐ **Initial Here** _____ *If adding a spouse/domestic partner or child(ren) a Change Form is required. Copies of Marriage Certificate/Domestic Partnership paperwork and 2021 Tax Return or Birth Certificates are required for coverage.*
Delta Dental Plan B - Group #6736-0003 Deductible $50 Individual / $150 Family Annual Maximum Allowance $2,000 (PPO) $1000 Orthodontics Annual Maximum (Children Only)	**$60.15**	**$106.93**	**$154.50**	☐ **Initial Here** _____ *If adding a spouse/domestic partner or child(ren) a Change Form is required. Copies of Marriage Certificate/Domestic Partnership paperwork and 2021 Tax Return or Birth Certificates are required for coverage.*
Delta Dental Plan C - Group #6736-01001 Deductible $50 Individual / $150 Family Annual Maximum Allowance $2,400 (PPO) This plan has implant coverage. $500 Orthodontics Annual Maximum (Adult/Children)	**$68.36**	**$121.57**	**$175.03**	☐ **Initial Here** _____ *If adding a spouse/domestic partner or child(ren) a Change Form is required. Copies of Marriage Certificate/Domestic Partnership paperwork and 2021 Tax Return or Birth Certificates are required for coverage.*
Delta Dental Plan D - Group #6736-01003 Deductible $50 Individual / $150 Family Annual Maximum Allowance $3,000 (PPO) This plan has implant coverage. $1000 Orthodontics Annual Maximum (Children Only)	**$76.38**	**$135.80**	**$196.18**	☐ **Initial Here** _____ *If adding a spouse/domestic partner or child(ren) a Change Form is required. Copies of Marriage Certificate/Domestic Partnership paperwork and 2021 Tax Return or Birth Certificates are required for coverage.*
☐ **Currently enrolled in Delta Dental but opting out of 2024 coverage.**				**Initial Here** _____
☐ **I would like to keep my current plan/eligible dependents.**				**Initial Here** _____
☐ **Not currently enrolled and I do not wish to enroll for 2024 coverage.**				**Initial Here** _____