DELTA DENTAL®

PSEA
VOLUNTARY ENROLLMENT GROUP DENTAL PROGRAM

Delta PPO ☐
Delta Premier B ☐
DeltaCare USA CA ☐
DeltaCare USA NV ☐

For Office Use Only
Effective Date _____
Group No. _____
Contract Type _____

PLEASE PRINT
Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City _____ State & Zip _____

Date of Birth ___/___/___ Male ☐ Female ☐ Phone (____) _____ SSN: _____

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Spouse _____ Born _____/_____/_____ Sex _____
Child _____ Born _____/_____/_____ Sex _____
Child _____ Born _____/_____/_____ Sex _____
Child _____ Born _____/_____/_____ Sex _____

I understand that I will be required to pay for these benefits. I agree to continue membership in this program for a minimum of 12 months and comply with the terms of the group contract.

Signature of Applicant: _____ Date ____/____/____

VISA / MC # _____ 3 digit sec _____ Exp:Date ____/____/____

If you have not yet retired: Expected Retirement Date ____/____/____ Home email address _____

Please return to PSEA, Suite 240, 1390 Willow Pass Rd, Concord, CA 94520

PACIFIC SERVICE EMPLOYEES ASSOCIATION
DELTA RATE SHEET
for Retiree & Associate Members of PSEA

RATES: Delta PPO	2024 QUARTERLY PRICING
Member only	$180.00
Member + 1 Dependent	$348.00
Member + 2 or more Dependents	$621.00

RATES: Delta Premier Table Plan	2024 QUARTERLY PRICING
Member only	$153.00
Member + 1 Dependent	$273.00
Member + 2 or more Dependents	$399.00

RATES: DeltaCare USA HMO - CA & NV only	2024 QUARTERLY PRICING
Member only	$132.00
Member + 1 Dependent	$219.00
Member + 2 or more Dependents	$327.00

***Please note: Delta coverage is to be paid quarterly. Please remit the first quarter payment, credit card or check made payable to "**PSEA**", along with your enrollment application.*