



FOR OFFICE USE ONLY
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**AETNA DMO DENTAL PLAN PRIMARY CARE DENTIST (PCD) ELECTION FORM
 ACTIVE EMPLOYEE / RETIREE**

STEP 1: Please PRINT or TYPE when you complete this form.

NAME: _____ SOCIAL SECURITY #: _____
 DATE OF BIRTH: _____ EFFECTIVE DATE OF COVERAGE: _____
 STREET: _____ PHONE-WORK-HOME: _____
 CITY/STATE: _____ ZIP: _____ DEPT: _____
 REASON: Open Enrollment
 New Employee Hire Date: _____
 Family Status Change Event: _____ Date of Event: _____

STEP 2: Complete this section for you and the dependent (s) you are adding to the DMO dental plan as of the above effective date. **If you fail to select a Primary Care Dentist, it will result in you not being able to utilize the DMO dental plan benefits on or after the effective date of your coverage.**

FULL NAME (PRINT)			Relationship	Sex	Social Security No.	DOB	Primary Care Dentist	Office ID #
First	Middle Initial	Last						
			SELF					
			SPOUSE					

STEP 3: You must complete this section with the Primary Care Dentist's address.

STREET: _____
 CITY/STATE: _____ ZIP CODE: _____

STEP 4: Read the statement below and sign your name.

By signing this form, I understand that my Aetna DMO dental plan premiums will be deducted on a pre-tax basis. No changes can be made to my dental plan enrollment during the plan year unless there is a family status change and I complete a benefits form **within 30 days** of the event. This form authorizes any licensed physician, hospital, or healthcare provider to furnish my health plan with such medical information about myself and any eligible dependent, as needed. I understand that my coverage and benefits may be adversely affected by my failure to provide complete and accurate information.

 Signature Date