PRINCE GEORGE'S COUNTY GOVERNMENT
BENEFITS AND PENSIONS DIVISION, 1400 McCORMICK DRIVE, SUITE 245, LARGO, MARYLAND 20774
MAIN (301) 883-6380 | FAX (301) 883-6192
BENEFITS@CO.PG.MD.US
DMO ELECTION FORM

FOR OFFICE USE ONLY

Completed By: _____

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) First	Middle Initial	Last	Relationship	Sex	Social Security No.	DOB	Primary Care Dentist	Office ID #
			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