OSMA Insurance Agency

Dental Benefits Enrollment Form
Delta Dental Point-of-Service (PPO)

Form must be signed by an OSMA member physician. Please type or print all information. Please fold and tape closed before mailing.

SPONSORING PHYSICIAN'S BILLING ADDRESS

Name ______________________________

Address ______________________________

City ______________ State ______________ ZIP ______________

Business Phone (________)______________ Business Fax (________) ______________

OSMA Member Physician Name)______________ Contact Name ______________

Email Address ______________________________

– IMPORTANT INFORMATION –

- ✓ Subscribers are required to remain enrolled for a minimum of 12 consecutive months unless terminated by employer
- ✓ All those choosing Delta Dental PPO should review the participating dentist directory.
- ✓ Form must be signed by OSMA member physician.

REQUESTED EFFECTIVE DATE

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(Please refer to brochure for schedule)

❍ Enrollment ❍ Termination

Please check: ❍ Physician

Name ______________ SS# ______________ Birth date ______________ Sex ______

Address ______________ City ______________ State ________ Zip ______________

List Dependents

	NAME	Sex	Birth Date		NAME	Sex	Birth Date
Date							
Spouse				Child			
Child				Child			

Please check: ❍ Physician ❍ Employee ❍ Other

Name ______________ SS# ______________ Birth date ______________ Sex ______

Address ______________ City ______________ State ________ Zip ______________

List Dependents

	NAME	Sex	Birth Date		NAME	Sex	Birth Date
Date							
Spouse				Child			
Child				Child			

Please check: ❍ Physician ❍ Employee ❍ Other

Name ______________ SS# ______________ Birth date ______________ Sex ______

Address ______________ City ______________ State ________ Zip ______________

List Dependents

	NAME	Sex	Birth Date		NAME	Sex	Birth Date
Date							
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Child				Child			

Please check: ❍ Physician ❍ Employee ❍ Other

Name ______________ SS# ______________ Birth date ______________ Sex ______

Address ______________ City ______________ State ________ Zip ______________

List Dependents

	NAME	Sex	Birth Date		NAME	Sex	Birth Date
Date							
Spouse				Child			
Child				Child			

OSMA Member Physician Signature ______________________________ ***Date*** ______________