Sheet Metal Workers' Health Plan
of Southern California, Arizona & Nevada
P.O. Box 10067 Manhattan Beach, CA 90266-8567
(800) 947-4338 or (310) 798-6572

Delta Dental Plan Enrollment Form

Effective Date:_____ **Group** _____**#5291-0501 (CA)**
_____**#5291-2901 (NV)**

Name _____ *Last four of SSN* _____

Address _____ *Phone* _____

Date of Birth _____

☐ Male ☐ Female ☐ Single ☐ Married

Eligible Dependents:

Last Name	First	MI	Social Security Number	Date of Birth	Relationship

***As a reminder*- Medical and Dental Plan selections may be changed only during the Annual Open Enrollment Period. Exceptions are made only if you move outside of your selected Plan's service area**.

_____ _____
Participant Signature *Date*