PRINCE GEORGE'S COUNTY GOVERNMENT
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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. **<u>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</u>**.

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 **<u>within 30 days</u>** 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