SOUTHERN CALIFORNIA PIPE TRADES
PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | www.scptac.org | health@scptac.org

Dental Benefit Enrollment Form

OPEN ENROLLMENT DEADLINE: November 30, 2025

NOTICE: All eligible participants interested in updating dental coverage must return a completed *Dental Benefit Enrollment Form* to the Fund Office via mail, fax or email at the address above by November 30, 2025.

You may terminate dental coverage at any time. However, once terminated, you may not re-enroll until the next open enrollment period.

If you do not return a completed *Dental Benefit Enrollment Form* by November 30, 2025, your dental coverage will remain unchanged.

PART 1—PARTICIPANT INFORMATION

Participant Name _____ Date of Birth _____

Social Security Number (only last four digits required) _____ **OR** Blue Shield ID No. IPE T50

Address (you must use a U.S. address to qualify for VSP) _____

Phone Number _____ Email Address _____

(You must provide a U.S. address in order to qualify for DeltaCare USA.)

PART 2 —DENTAL BENEFIT ELECTION (Check One)

I elect the following dental benefit option effective January 1, 2026:

		Monthly Cost	
A ☐	**NO DENTAL COVERAGE**	**Skip to Part 6**	
B ☐	**OPTION 1 – DELTACARE USA HIGH HMO**	Pensioner (or Surviving Spouse) only: Pensioner & Spouse:	$22.51 $44.93
C ☐	**OPTION 2 – DELTACARE USA MEDIUM HMO**	Pensioner (or Surviving Spouse) only: Pensioner & Spouse:	$15.47 $30.74
D ☐	**OPTION 3 – METLIFE PPO**	Pensioner (or Surviving Spouse) only: Pensioner & Spouse:	$65.56 $131.12

PART 3 —DENTAL COVERAGE ELECTION (Check One)

I elect to cover:

A ☐ **MYSELF ONLY**
B ☐ **MYSELF AND MY ELIGIBLE SPOUSE**

SIX-DIGIT DELTACARE USA FACILITY CODE * (Optional) _____

(Continued on reverse…)

PART 4 —PENSION DEDUCTION AUTHORIZATION

☐ **I HAVE ELECTED TO ENROLL IN DENTAL COVERAGE IN PART 2 OF THIS FORM, AM RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND SUFFICIENT TO COVER MY MEDICAL AND DENTAL PREMIUMS AND HEREBY AUTHORIZE THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND TO DEDUCT FROM MY MONTHLY BENEFIT PAYMENTS SUCH SUMS AS ARE PERIODICALLY ESTABLISHED BY THE TRUSTEES OF THE SOUTHERN CALIFORNIA PIPE TRADES PENSIONERS & SURVIVING SPOUSES HEALTH FUND TO PROVIDE DENTAL COVERAGE UNDER THAT FUND**.

I understand that this amount will likely increase over time. I make this authorization voluntarily and understand that it may be revoked at any time. By this authorization, I am not assigning my monthly benefit payment or any portion thereof, to the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund. I understand that the Pensioners & Surviving Spouses Health Fund has no right, enforceable against the Southern California Pipe Trades Retirement Fund, to any part of the monthly pension benefit. I understand that if this authorization is revoked, I must provide an ACH Authorization Form so that my monthly dental premiums can be deducted from my bank account. I also understand that failure to do so will result in the loss of dental coverage under the Pensioner & Surviving Spouses Health Fund. I understand that no other forms of payment will be accepted.

PART 5 —ACH ELECTRONIC PAYMENT AUTHORIZATION

IF YOU COMPLETED PART 4, **SKIP THIS PART**.

IF YOU ARE ELECTING DENTAL COVERAGE AND ARE NOT RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND OR YOUR PENSION BENEFIT IS **NOT** SUFFICIENT TO COVER YOUR MEDICAL AND DENTAL PREMIUMS, **YOU MUST COMPLETE THIS PART** TO PAY FOR YOUR MEDICAL AND DENTAL COVERAGE THROUGH AN AUTOMATIC, MONTHLY DEDUCTION FROM YOUR BANK ACCOUNT.

By signing in Part 6 below, I authorize the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund to electronically withdraw from or deposit into my checking or savings account indicated below amounts necessary to provide dental benefits as determined by the Board of Trustees of the Fund.	
Depository Name (Bank, Savings & Loan or Credit Union)	
Transit/ABA/Routing Number	**Account Number**
Account Type ☐ **Checking** ☐ **Savings**	**Social Security Number** **(only last four required)**
This authorization will remain in full force and effect until the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund has received, at least two weeks before the scheduled payment date, written notification from me that I want to revoke this authorization.	
Account holder must verify bank account data. Please attach a voided check.	

PART 6 —PARTICIPANT AGREEMENT AND SIGNATURE

I have read and understand the material provided describing my dental benefit options. I have asked any questions to the Southern California Pipe Trades Administrative Corporation, DeltaCare USA, MetLife and have received acceptable answers.

I understand that if I do not return a completed *Dental Benefit Enrollment Form* my dental coverage will remain unchanged.

I understand that I will not be permitted to obtain or change my dental plan again until the next open enrollment period, which is scheduled for late 2026, for changes effective January 1, 2027.

* I understand that if I do not enter a Facility Code in Part 3, DeltaCare USA will assign me to a primary dentist based on the first in-network dental provider that files a claim. Thereafter, I will be permitted to change my dentist by contacting DeltaCare USA.

IF I AM NOT RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND, I HAVE COMPLETED THE ACH AUTHORIZATION IN PART 5 ABOVE.

X _____ _____

Pensioner (or Surviving Spouse) Signature Date

2025OEDEF_PEN