UUP Member Services Trust
Voluntary Dental & Vision Enrollment Form*

Program Selection

Select the applicable box or boxes

DELTA DENTAL

Coverage Effective Date: _____

☐ **Delta Dental PPO – Option 1**

☐ **DeltaCare® USA DHMO – Option 2**

If you select the DeltaCare® USA DHMO Option you must provide the name of your DeltaCare® USA Primary Dentist and Office Facility number or one will be assigned to you. You can locate a DeltaCare® USA dentist by calling Delta Dental Customer Service at 800-471-7093 or visit www.deltadentalins.com/uup.

DeltaCare® USA Primary Dentist_____

Dental Office Facility Number _____

DAVIS VISION
EYECARE REFRAMED℠

Coverage Effective Date:_____

☐ **Davis Vision**

Make checks payable and mail to:
UUP Member Services Trust
P.O. Box 15143
Albany, NY 12212-5143
800-887-3863
Fax: 866-559-0516

Group# NY 00166

You must be a UUP Member (and not an agency fee payer) or be directly related to a UUP Member to purchase these programs.

Member Information – This section must be completed – Please print clearly

Name (Last) (M.I.) (First)	Date of Birth	NYS Employee ID or SSN #

Street Address Apt.	City, State, Zip	Campus

Type of Coverage		Marital Status	Telephone / Email
☐ Individual ☐ Two Person ☐ Family	☐ UUP Retiree ☐ Part Time UUP Member ☐ Surviving Spouse of UUP Member ☐ Surviving Domestic Partner ☐ Aged-out Dependent up to the age of 29	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated	Home Telephone: _____ Work Telephone: _____ Email Address: _____

Enrollment	Name (Last)	Name (First)	Social Security Number	Date of Birth	Gender
Member					☐M ☐F
☐ Spouse ☐ Domestic Partner					☐M ☐F
Dependent					☐M ☐F
Dependent					☐M ☐F
Dependent					☐M ☐F

I hereby represent that all information furnished is true and complete to the best of my knowledge.

Signature: _____ Date_____

If you have any questions regarding the UUP Member Services Trust Voluntary Dental and Vision Programs, please contact the UUP Member Services Trust at 1-800-887-3863.