DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA
DUAL CHOICE

Delta Dental of California

www.deltadentalins.com

Select a Plan: ☐ **PPO** P.O. Box 429086 San Francisco, CA 94142-9086 **OR** ☐ **DeltaCare® USA[1] HMO** P.O. Box 1803 Alpharetta, GA 30023

VERY IMPORTANT - Please Print Legibly

Enrollee/Change Information

☐ New Enrollment
☐ Add/Delete Dependent
☐ Marital Status Change
☐ Address Change
☐ Terminate Enrollee Coverage
☐ Change Dental Plans*
☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

*Enrollees can change plans only during open enrollment or due to a qualifying status change unless allowed by the group contra ct.

Change Dental Plan*

☐ **PPO - Cancel**

☐ **DeltaCare USA HMO- Cancel**

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

Enrollee Classification

☐ Full-Time ☐ Hourly ☐ Certified
☐ Part-Time ☐ Salaried ☐ Classified
☐ Retired ☐ Member/Other _____

COBRA (if applicable)

☐ Termination
☐ Reduction in Hours
☐ Divorce/Legal Separation**
☐ Widowed/Surviving Dependent**
☐ Dependent Child No Longer Eligible**

Indicate qualifying date: ____/____/____

If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided.

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	☐ Male ☐ Female	☐ Single ☐ Married

First Name	Last Name	Middle Initial

Mailing Address (Street)	City	State	Zip Code

E-mail Address (internal use only)	Phone Number ( ) -	Phone Type Cell ☐ Work ☐ Home ☐

Network Facility Name (DeltaCare USA only)	Network Facility Number (DeltaCare USA only)

Name of Other Dental Carrier	Policy Holder Name (first/last)	Date of Birth
		/ /

Effective Date of Other Policy	Policy Holder Street Address	City	State	Zip Code
/ /				

Dependent Information

Relationship	Dependent First Name (last name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled***	Name of School (overage student)***	Network Facility Number ‡ (DeltaCare USA only)
Spouse/Partner		☐ ☐		/ /	☐ ☐	☐ ☐		
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐		
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐		
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐		

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. ***Addi tional documentation will be required for disabled and student st atus. ‡Maximum of three facilities per family.

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event , or as may otherwise be provided by the group contract.

☐ I decline coverage at this time.

Signature of Enrollee _____ Date ____/____/____

[1]DeltaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enr ollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.