DELTA DENTAL

# ENROLLMENT/CHANGE FORM - CA
# DUAL CHOICE
## Delta Dental of California

www.deltadentalins.com

**Select a Plan:** ☐ **Fee-For-Service** OR ☐ **DeltaCare® USA**[1]

Fee-For-Service: P.O. Box 429086, San Francisco, CA 94142-9086

DeltaCare USA: P.O. Box 1803, Alpharetta, GA 30023

**VERY IMPORTANT - Please Print Legibly**

## FOR GROUP USE ONLY

| Group No. | Division | State |
|---|---|---|
| | | |

| Effective Date / / | Hire Date / / |
|---|---|
| Name of Employer | |

| Location | Pay Code | Benefit Package |
|---|---|---|
| | | |

## Enrollee/Change Information

☐ New Enrollment ☐ Address Change ☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

☐ Add/Delete Dependent ☐ Terminate Enrollee Coverage

☐ Marital Status Change ☐ Change Dental Plans*

## Change Dental Plan*

☐ Fee-For-Service - Cancel

☐ DeltaCare USA - Cancel

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

## 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. ***Additional documentation will be required for disabled and student status. ‡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.