DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA
DUAL CHOICE

Delta Dental of California

www.deltadentalins.com

Select a Plan: ❑ **Fee-For-Service PPO** **OR** ❑ **DeltaCare® USA HMO**

P.O. Box 429086
San Francisco, CA 94142-9086

❑ [1] 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
❑ 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*

❑ **Fee-For-Service - Cancel**

❑ **DeltaCare USA - Cancel**

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 ❑ Male ❑ Female	Marital Status ❑ 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.