DELTA DENTAL

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

www.deltadentalins.com

Select a Plan: ❑ DPO / PPO OR ❑ DeltaCare® USA HMO[1]

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

Name of Olher 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 ‡ (DellaCare 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]DellaCare 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 DellaCare USA network from whom they receive treatment.