DELTA DENTAL®

ENROLLMENT/CHANGE FORM - CA
DUAL CHOICE

Delta Dental of California

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
20499	2	

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. Enrollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to receive this document in Spanish or Chinese. For free help, please call Delta Dental:

Delta Dental Premier®
and Delta Dental PPO℠: 1-800-765-6003
DeltaCare® USA: 1-800-422-4234

IMPORTANTE: ¿Pueda leer este documento? Si no, podenmos ayudarle. También puede recibir este documento en español o chino. Para obtener ayuda gratis, llame a Delta Dental al:

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DeltaCare® USA: 1-800-422-4234

重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。您也能取得這份文件的西班牙文或中文譯本。 如需免費協助，請電 Delta Dental。

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