A DELTA DENTAL ENROLLMENT/CHANGE FORM - O DUAL CHOICE							CA					GRO		E ON						
DUAL CHOICE Delta Dental of California												Group No. Effective		Division		State				
deltadentalins.com	Select a Plan: Fee-For-Service OR DeltaCare® USA ¹ P.O. Box 429086 DeltaCare® USA ¹ P.O. Box 1803									Date / Name of Emp	/ loyer	Date	/	1						
VERY IMPORTANT - Please Print Legibly San Francisco, CA 94142-9086 Alpha								Alpharetta, GA 30023				Location	F	Pay Code	Benef	it Package				
Enrollee/Change Information Change Dental Plan*														า*	Enrollee Classification					
 New Enrollment Add/Delete Dependent Marital Status Change 	 Address Change Terminate Enrollee Cov Change Dental Plans* 	on or are rece	ived	Image: Fee-For-Service - Cancel Image: Fee-For-Service - Cancel Image: Fee-For-Service - Cancel Image: Fee-For-Service - Cancel Image: Fee-For-Service - Cancel Image: Fee-For-Service - Cancel						 Full-Time Hourly Certified Part-Time Salaried Classified Retired Member/Other 										
*Enrollees can change plans	only during open enrollment or							roup contra	xt.											
			nary Er	nrollee			on								COBRA (if applicable)					
Social Security Number												al	 Termination Reduction in Hours 							
Mailing Address (Street) City								State Zip Code							Divorce/Legal Separation**					
E-mail Address (internal use only) Phone Number (-	Phone Type Cell D Work D Home D						 Widowed/Surviving Dependent** Dependent Child No Longer Eligible** 					
Network Facility Name (DeltaCare USA only) Network Facility Number (DeltaCare USA only)												Indicate qualifying date: / /								
Name of Other Dental Carrier Policy Holder Name (first/last)								Date of Birth						1	**If a dependent is enrolling under his/her social					
Effective Date Policy Holder Street Address City								State Zip Code							security number, the SSN currently enrolled under must be provided.					
					I	Depen	dent	Informa	atio	n										
	ependent First Name me only if different from enrollee)	Add / Te	erm S	ocial Secu	urity Nur	mber	Da	ate of Birth	Ν	/lale /	Female	Studen	t / Disabled**	•	Name of Scho (overage studen			Facility I aCare USA	Number ‡	
Spouse/Partner								/ /							(oronago stadon	1	(200			
Dependent																				
Dependent																				
Dependent																				
Please attach a separate shee	t for additional dependent infor	mation. A	l depender	ts listed w	vill be co	onsidered	enrolled	I. ***Addition	al doo	cumer	ntation w	ill be req	uired for disat	led and	student status.	‡Maximur	m of three fa	cilities p	er family.	
	yroll deduction that may be if I experience a qualifying e at this time.																		changes	
Signature of Enrollee _														Date	/		/		_	
¹ DeltaCare USA is our prepaid	plan that features set copayme	nts, no anr	ual deducti	bles and n	io maxin	nums for c	overed	benefits. Enro	llees	must	select a	primary c	are dentist in	he Delta	Care USA netwo	ork from v	vhom they re	ceive		

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 PPOSM: 1-800-765-6003 DeltaCare[®] USA: 1-800-422-4234

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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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