



ENROLLMENT/CHANGE FORM - CA DUAL CHOICE

Delta Dental of California

deltadentalins.com

Select a Plan: **Fee-For-Service** OR **DeltaCare® USA¹**
P.O. Box 429086 San Francisco, CA 94142-9086 P.O. Box 1803 Alpharetta, GA 30023

VERY IMPORTANT - Please Print Legibly

Enrollee/Change Information		
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Address Change	<input type="checkbox"/> SSN/Enrollee ID Number Correction or previous ID under which benefits are received
<input type="checkbox"/> Add/Delete Dependent	<input type="checkbox"/> Terminate Enrollee Coverage	
<input type="checkbox"/> Marital Status Change	<input type="checkbox"/> Change Dental Plans*	

Change Dental Plan*
<input type="checkbox"/> Fee-For-Service - Cancel
<input type="checkbox"/> DeltaCare USA - Cancel

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

Primary Enrollee Information					
Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status	
		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> 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 <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/>		
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

FOR GROUP USE ONLY		
Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package
Enrollee Classification		
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Hourly	<input type="checkbox"/> Certified
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Salaried	<input type="checkbox"/> Classified
<input type="checkbox"/> Retired	<input type="checkbox"/> Member/Other _____	
COBRA (if applicable)		
<input type="checkbox"/> Termination		
<input type="checkbox"/> Reduction in Hours		
<input type="checkbox"/> Divorce/Legal Separation**		
<input type="checkbox"/> Widowed/Surviving Dependent**		
<input type="checkbox"/> 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.		

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		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		

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 / /

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

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

Delta Dental Premier[®]
and Delta Dental PPOSM: 1-800-765-6003
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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