



ENROLLMENT/CHANGE FORM - CA DUAL CHOICE

Delta Dental of California

www.deltadentalins.com

Select a Plan: DPO / PPO OR DeltaCare® USA HMO¹

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 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.		

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	

Dependent Information								
Relationship	Dependent First Name <small>(last name only if different from enrollee)</small>	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled***	Name of School <small>(coverage student)***</small>	Network Facility Number † <small>(DeltaCare USA only)</small>
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.