



# ENROLLMENT/CHANGE FORM - CA DUAL CHOICE

Delta Dental of California

www.deltadentalins.com

Select a Plan:  **Fee-For-Service** PPO **OR**  **DeltaCare® USA<sup>1</sup>** HMO  
P.O. Box 429086 San Francisco, CA 94142-9086  
P.O. Box 1803 Alpharetta, GA 30023

**VERY IMPORTANT - Please Print Legibly**

### Enrollee/Change Information

- New Enrollment
- Add/Delete Dependent
- Marital Status Change
- Address Change
- Terminate Enrollee Coverage
- Change Dental Plans\*
- SSN/Enrollee ID Number Correction or previous ID under which benefits are received

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

### Change Dental Plan\*

- Fee-For-Service - Cancel**
- DeltaCare USA - Cancel**

### Primary Enrollee Information

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

- Full-Time
- Part-Time
- Retired
- Hourly
- Salaried
- Member/Other \_\_\_\_\_
- Certified
- Classified

### 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.**

### 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 / /

<sup>1</sup>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.