



ENROLLMENT/CHANGE FORM - CA DUAL CHOICE

Delta Dental of California

www.deltadentalins.com

Select a Plan:

Fee-For-Service

OR

DeltaCare® USA¹

P.O. Box 429086
San Francisco, CA 94142-9086

12898 Towne Center Drive
Cerritos, CA 90703-8579

VERY IMPORTANT - Please Print Legibly

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* _____

*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

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

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 <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

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.