DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California + 0 2

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State

Effective Date / /	Hire Date / /

Employee Classification

Name of Employer

Location	Pay Code	Benefit Package

Enrollee/Change Information

‰ New Enrollment ‰ Marital Status Change ‰ Terminate Enrollee Coverage ‰ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

‰ Add/Delete Dependent ‰ Address Change ‰ Other _____

Enrollee Classification

‰ Full-Time ‰ Hourly ‰ Certified

‰ Part-Time ‰ Salaried ‰ Classified

‰ Retired ‰ Member/Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	‰ Male ‰ Female	‰ Single ‰ 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 ‰ Work ‰ Home ‰

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

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 only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse/Partner		‰	‰	/ /	‰	‰ ‰	‰
Dependent		‰	‰	/ /	‰	‰ ‰	‰
Dependent		‰	‰	/ /	‰	‰ ‰	‰
Dependent		‰	‰	/ /	‰	‰ ‰	‰
Dependent		‰	‰	/ /	‰	‰ ‰	‰

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.

‰ 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.

Signature of Enrollee _____ Date ____/____/____