



# ENROLLMENT/CHANGE FORM - CA

DeltaCare® USA

Enrollment and Billing Department  
P.O. Box 1803  
Alpharetta, GA 30023  
www.deltadentalins.com

**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/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 <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	Network Facility Number			
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 name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (coverage student)**	Network Facility Number †
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 / /

**IMPORTANT:** Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 1-800-422-4234. You may also be able to receive this document in Spanish or Chinese.

**IMPORTANTE:** ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 1-800-422-4234. También puede recibir este documento en español o chino.

**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。如需免費協助，請電 Delta Dental 1-800-422-4234 您也能取得這份文件的西班牙文或中文譯本。