DELTA DENTAL

# ENROLLMENT/CHANGE FORM - CA

DeltaCare® USA

# DeltaCare HMO Dental

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

**VERY IMPORTANT - Please Print Legibly**

## FOR GROUP USE ONLY

| Group No. | Division | State |
|---|---|---|
| 71986 | 9215 | CA |

| Effective Date | Hire Date |
|---|---|
| / / | / / |

Name of Employer: Lawndale Elementary School District

| 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 ❑ |

| 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 (overage student)** | Network Facility Number‡ |
|---|---|---|---|---|---|---|---|---|
| Spouse/Partner | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | | |
| 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. ‡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 ____/____/____



CC: L. Diaz, file