

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Orthodontic Benefits 2026
Adults & Dependent ChildrenDelta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com☐ Single \$ 61.95☐ 2-Party \$ 117.70☐ Family \$ 179.64

VERY IMPORTANT - Please Print Legibly

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 _____

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

FOR GROUP USE ONLY

Group No. 22920	Division 1000 & 1001	State CA
Effective Date ____/____/____	Hire Date ____/____/____	
Name of Employer NATOMAS UNIFIED SD		
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.**

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 (coverage 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.

☐ I decline coverage at this time.

Signature of Enrollee _____

Date ____/____/____