

Website

HRS

www.deltadentalins.com

Select a Plan:

PPO Fee-For-Service

OR

HMO DeltaCare® USA¹
P.O. Box 1803 Alpharetta, GA
30023

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 ☐ Male ☐ Female		Marital Status ☐ 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 (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 4 (DeltaCare USA only)
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 / /

¹ DeltaCare 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.