



ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Choose one:

- ☐ High Plan
☐ Premium Plan
☐ Low Plan

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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

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 / /

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.