



ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California
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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 |
| / / | | / / | <input type="checkbox"/> Male <input type="checkbox"/> Female | <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"/> | | |
| 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. | 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.**

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 | | <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"/> | |
| 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.

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 / /