DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California (HMO)

Delta Dental of California
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VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State

Effective Date	Hire Date

Name of Employer

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

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 ☐

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 (overage 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 _____