



# ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California  
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**VERY IMPORTANT - Please Print Legibly**

Enrollee/Change Information			
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Marital Status Change	<input type="checkbox"/> Terminate Enrollee Coverage	<input type="checkbox"/> SSN/Enrollee ID Number Correction or previous ID under which benefits are received
<input type="checkbox"/> Add/Delete Dependent	<input type="checkbox"/> Address Change	<input type="checkbox"/> 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		
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Hourly	<input type="checkbox"/> Certified
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Salaried	<input type="checkbox"/> Classified
<input type="checkbox"/> Retired	<input type="checkbox"/> Member/Other _____	
COBRA (if applicable)		
<input type="checkbox"/> Termination		
<input type="checkbox"/> Reduction in Hours		
<input type="checkbox"/> Divorce/Legal Separation*		
<input type="checkbox"/> Widowed/Surviving Dependent*		
<input type="checkbox"/> Dependent Child No Longer Eligible*		
Indicate qualifying date: / /		
*If a dependent is enrolling under his/her social security number, the <b>SSN currently enrolled under must be provided.</b>		

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.

<input type="checkbox"/> 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.
<input type="checkbox"/> I decline coverage at this time.
Signature of Enrollee _____ Date _____ / _____ / _____