ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Small Business Program

Select a Plan: ❑ PPO Delta Dental of California OR ❑ DeltaCare® USA[1] Delta Dental of California

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date	Hire Date	
Name of Employer		

❑ Add/Term/Change Due to Qualifying Event

❑ Open Enrollment

Enrollee/Change Information

❑ New Enrollment
❑ Add/Delete Dependent
❑ Marital Status Change
❑ Address Change
❑ Terminate Enrollee Coverage
❑ Change Dental Plans[2]
❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

Change Dental Plan[2]

❑ **PPO – Cancel**
❑ **DeltaCare USA – Cancel**

Primary Enrollee Information

Social Security Number	Date of Birth	Gender ❑ Male ❑ Female ❑ Non-binary	Marital Status ❑ Single ❑ Married
First Name	Last Name	Middle	
Mailing Address (Street)	City	State	Zip
E-mail Address (internal use only)	Phone Number	Phone Type ❑ Cell ❑ Work ❑ Home	
Network Facility Name[5]	Network Facility Number[5]		
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

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified
❑ Retired ❑ Salaried ❑ Classified
❑ 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 their own social security number, the **SSN currently enrolled under must be provided**.

Dependent Information[3]

Relationship	Dependent First Name (Last only if different from enrollee)	Add/Term	Date of Birth	Male/Female/Non-binary	Disabled[4]	Network Facility Number[5]
Spouse/Partner		❑ ❑		❑ ❑ ❑	❑	
Dependent		❑ ❑		❑ ❑ ❑	❑	
Dependent		❑ ❑		❑ ❑ ❑	❑	
Dependent		❑ ❑		❑ ❑ ❑	❑	
Dependent		❑ ❑		❑ ❑ ❑	❑	

[1] DeltaCare USA is our closed network 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.

[2] Enrollees can change plans only during open enrollment or due to a qualifying status change.

[3] Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled.

[4] Additional documentation, in the form of a doctor's note, will be required for disabled status.

[5] To be completed only when choosing DeltaCare USA. There is a maximum of three facilities per family.

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DENTAL

- ❑ 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 during the annual open enrollment period unless 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 have been offered coverage by my employer, but at this time I wish to decline dental coverage for:

  ❑ Myself and my dependents ❑ Spouse/Partner ❑ Child(ren)

Reason

Required only if employee waiving coverage — not required if waiving coverage for dependents only

- ❑ Other Group Coverage Carrier Name ________________________ Group #________________
- ❑ Medicare/Medicaid provided dental coverage
- ❑ Individual Policy
- ❑ Other Reason ____ (explanation required)

Signature of Enrollee ____ Date ____