# ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

**Small Business Program**

Combined Dental/Vision - DeltaCare® USA[1]

**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 ❑ 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 | 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 | |
| Coverage type ❑ Dental ❑ Vision | | | |
| Network Facility Name | Network Facility Number | | |
| Name(s) of Other Dental Carrier and/or Vision Carrier | Policy Holder Name (first/last) | Date of Birth | |
| Effective Date(s) of Other Policies | 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[2]

| Relationship | Dependent First Name (Last only if different from enrollee) | Dental/Vision | Add/Term | Date of Birth | Male/Female/Non-binary | Disabled[3] | Network Facility Number[4] |
|---|---|---|---|---|---|---|---|
| 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] Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. Primary enrollee must be enrolled in a coverage type in order to add dependents.

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

[4] Maximum of three facilities per family.

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## DENTAL AND VISION

- ❑ 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 dental 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)

- ❑ I have been offered coverage by my employer, but at this time I wish to decline vision coverage for:

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

**Reason**

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

❑ Other Group Coverage Carrier Name ________________________ Group #_________________
❑ Medicare/Medicaid provided vision coverage
❑ Individual Policy
❑ Other Reason ____________________________________________________ (explanation required)

Signature of Enrollee ______________________________________________________________ Date ____________________________________________________