



# 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.

Signature of Enrollee \_\_\_\_\_

Date    /    /

**IMPORTANT:** Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 1-800-765-6003. You may also be able to receive this document in Spanish or Chinese.

**IMPORTANTE:** ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 1-800-765-6003. También puede recibir este documento en español o chino.

**重要通知：** 您能讀這份文件嗎？如有問題，我們可請他人協助您。如需免費協助，請電 Delta Dental 1-800-765-6003 您也能取得這份文件的西班牙文或中文譯本。