DELTA DENTAL®

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Small Business Program

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		Date of Birth	Gender ❑ Male ❑ Female	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	
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

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 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 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	Date of Birth	Male/Female	Disabled**
Spouse/Partner		❑ ❑		❑ ❑	❑
Dependent		❑ ❑		❑ ❑	❑
Dependent		❑ ❑		❑ ❑	❑
Dependent		❑ ❑		❑ ❑	❑
Dependent		❑ ❑		❑ ❑	❑

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation, in the form of a doctor's note, will be required for disable status. will be required for disabled 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 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 decline coverage at this time.

Signature of Enrollee _____ Date _____