



# ENROLLMENT/CHANGE FORM

Delta Dental of California

Delta Dental of California  
P.O. Box 429086  
San Francisco, CA 94142-9086  
www.deltadentalins.com

**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.

I decline coverage at this time.

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

Date / /