DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Small Business Program

Combined Dental/Vision

Select a Plan: ❑ **PPO** Delta Dental of California OR ❑ **DeltaCare® USA**[1] Delta Dental of California AND/OR ❑ **DeltaVision®** 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 ❑ Address Change ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

❑ Add/Delete Dependent ❑ Terminate Enrollee Coverage

❑ Marital Status Change ❑ Change Dental Plans[2]

Change Plan[2]

❑ **PPO – Cancel**
❑ **DeltaCare USA - Cancel**
❑ **DeltaVision - Cancel**

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**.

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[5]	Network Facility Number[5]

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

Dependent Information[3]

Relationship	Dependent First Name (Last only if different from enrollee)	Dental/Vision	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. Primary enrollee must be enrolled in a coverage type in order to add dependents.

[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 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)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Enrollee _____ Date _____