DELTA DENTAL®

ENROLLMENT/CHANGE FORM - CA

DeltaCare® USA

HMO

Enrollment and Billing Department
P. O. Box 1803
Alpharetta, GA 30023
deltadentalins.com

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No. 78648	Division 00001	State CA
Effective Date / /	Hire Date / /	
Name of Employer: La Mesa-Spring Valley		
Location	Pay Code	Benefit Package

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 _____

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified

❑ Part-Time ❑ Salaried ❑ Classified

❑ Retired ❑ Member/Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	❑ Male ❑ Female	❑ Single ❑ 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 ❑ Work ❑ Home ❑

Network Facility Name	Network Facility Number

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
/ /				

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 name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (overage student)**	Network Facility Number‡
Spouse/Partner		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		

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. ‡Maximum of three facilities per family.

❑ 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 ____/____/____

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-XXX-XXX-XXXX.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-XXX-XXX-XXXX. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。
這封信也可以用您所講的語言書寫。如需幫助，請立即撥打登列在您的Delta Dental ID卡背面上的會員/客戶服務部的電話，或者撥打電話 1-XXX-XXX-XXXX。(Chinese)