



ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California
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VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date	Hire Date	
Name of Employer		
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	<input type="text"/>

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.**

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender Male Female	Marital Status 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		
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

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 (overage student)**
Spouse/Partner							
Dependent							
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.

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 _____