DELTA DENTAL

California Dual-Choice Enrollment Form

Please select ONE of the following dental plans:

Fee-for-service plan

☐ Delta Dental Premier®
☐ Delta Dental PPO

For internal use only – fee-for-service
Group/Employer number: _____
ID number: _____
Effective date: _____

Prepaid DHMO plan:

☐ DeltaCare USA®

You must select a network dentist for this plan

Dental office name: _____

Office number ID code (required): _____

For internal use only - prepaid
Group/Employer number: _____
ID number: _____
Effective date: _____

Group Division Number: _____ Group Name: _____

Date Employed:

_____

Employee Classification:
☐ Full-time
☐ Part-time
☐ Salaried
☐ Hourly
☐ Certificated
☐ Classified
☐ Retired
☐ COBRA

Primary Enrollee Information:

Name: _____
Address: _____
City, state & ZIP: _____
Home phone number: (___) _____
E-mail address: _____
Date of birth: _____/_____/_____ ☐ Male ☐ Female
Social security number: _____
Network Facility Name (Delta Use Only) _____
Network Facility Number: (Delta Use Only) _____

Action Requested:

☐ New enrollment
☐ Add dependent
☐ Remove dependent
☐ Name change
☐ Address change
☐ Social security number correction
☐ COBRA Enrollment

☐ **COBRA Enrollment Only**

I understand that I may be required by the employer to pay for COBRA benefits.

Note: If dependent is enrolling under own social security number (SSN), the original enrollee's social security number must be supplied.

Primary enrollee's SSN:
_____

Qualifying date:
_____/_____/_____

Qualifying reason:
_____

Marital Status

☐ Single ☐ Married
☐ Divorced ☐ Separated
☐ **Domestic Partnership**

Do you have dependent children?
☐ Yes ☐ No

Does your spouse have a dental plan?
☐ Yes ☐ No

Who is covered by spouse?
☐ Yourself ☐ Spouse ☐ Dependent children

If Delta Dental, indicate group number:
_____

Dependent Information:

Spouse/domestic partner Name (Last, First, MI)	Code*	Spouse's SSN	Date of birth	Email	Marriage/Divorce date ___/___/___	M	F
						☐	☐

Child(ren): Name (Last, First, MI)	Code*	Child's SSN	Date of birth	Email	If 19 or older, indicate: Full-time student	Disabled	M	F
					___ ☐	☐	☐	☐
					___ ☐	☐	☐	☐
					___ ☐	☐	☐	☐
					___ ☐	☐	☐	☐

For DeltaCare USA enrollees only:

Dental office name / Network Facility Name	Dental office ID code / Network Facility Number
Dental office name	Dental office ID code

Relationship Codes: Spouse – SP Domestic Partner – DP Child – CH Child of DP – CD Other Adult – OA Other Child -OC

I understand that I may be required by the employer to pay for these benefits and those for my dependents. I agree to continue membership in the program selected above during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature: _____ **Date:** _____