VISION SERVICE PLAN
ENROLLMENT / CHANGE FORM

Employee Name _____ Social Security # _____

Address _____ Date of Birth _____

_____ Phone # _____

Dependents:	Date of Birth	Circle One
_____	_____	ADD TERMINATE
_____	_____	ADD TERMINATE
_____	_____	ADD TERMINATE
_____	_____	ADD TERMINATE
_____	_____	ADD TERMINATE

I UNDERSTAND THAT ENROLLMENT IN THIS COVERAGE MUST BE CONTINUOS. TERMINATION AND RE-ENROLLMENT IN THIS PLAN IS NOT PERMITTED. (*EXCEPT FOR QUALIFYING EVENT*)

_____ _____

SIGNATURE DATE

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: _____

Date Employed: _____

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

Group Division Number: _____ Group Name: _____

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
- ☐ COBRAenrollment

☐ 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 ☐ Domestic Partnership
☐ Divorced ☐ Separated

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	E-mail	Marriage/Divorce date	M	F
						☐	☐

Child(ren): Name (Last, First, MI)	Code*	Spouse's SSN	Date of birth	E-mail	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, I agree to comply with the terms of the group contract.

Enrollee Signature: _____ **Date:** _____