DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California
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San Francisco, CA 94142-9086
www.deltadentalins.com

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
16326	00002	CA

Effective Date / / | Hire Date / /

Name of Employer: CVCHS

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 _____

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 ☐

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

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.**

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 / /