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. 163 26	Division 00002	State CA
Effective Date / /	Hire Date / /	
Name of Employer CVCHS		
Location	Pay Code	Benefit Package

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.**

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 ☐ 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 ___/___/___