



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
- 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 Domestic
 - Divorced Separated 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: _____

For DeltaCare USA enrollees only:

Dependent Information:		Spouse's SSN		Date of birth		E-mail		Marriage/Divorce date		M F		Dental office name		Dental office ID code	
Spouse/domestic partner Name (Last, First, MI)	Code*	Spouse's SSN	Code*	Date of birth	E-mail	Date of birth	E-mail	Full-time student	Disabled	M	F	Dental office name	Network Facility Name	Network Facility Number	Dental office ID code
Children):	Code*	Child's SSN	Code*	Date of birth	E-mail	Date of birth	E-mail	Full-time student	Disabled	M	F	Dental office name	Network Facility Name	Network Facility Number	Dental office ID code
_____	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____

*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: _____