DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA Delta

Dental of California & Vision Service Plan (VSP)

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State

Effective Date / /	Hire Date / /

Name of Employer

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 ____/____/____