



# ENROLLMENT/CHANGE FORM - CA

Delta Dental of California  
Small Business Program  
Combined Dental/Vision

Select a Plan: ☐ **PPO** OR ☐ **DeltaCare® USA¹** AND/OR ☐ **DeltaVision®**  
Delta Dental of California Delta Dental of California Delta Dental of California

VERY IMPORTANT - Please Print Legibly

Enrollee/Change Information			
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Address Change	<input type="checkbox"/> SSN/Enrollee ID Number Correction or previous ID under which benefits are received	
<input type="checkbox"/> Add/Delete Dependent	<input type="checkbox"/> Terminate Enrollee Coverage		
<input type="checkbox"/> Marital Status Change	<input type="checkbox"/> Change Dental Plans²		

Change Plan²	
<input type="checkbox"/> PPO - Cancel	
<input type="checkbox"/> DeltaCare USA - Cancel	
<input type="checkbox"/> DeltaVision - Cancel	

Primary Enrollee Information				
Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
First Name	Last Name		Middle	
Mailing Address (Street)	City	State	Zip	
E-mail Address (internal use only)	Phone Number	Phone Type <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home		
Coverage type <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
Network Facility Name⁵		Network Facility Number⁵		
Name(s) of Other Dental Carrier and/or Vision Carrier		Policy Holder Name (first/last)		Date of Birth
Effective Date(s) of Other Policies	Policy Holder Street Address	City	State	Zip

FOR GROUP USE ONLY		
Group No.	Division	State
Effective Date	Hire Date	
Name of Employer		
<input type="checkbox"/> Add/Term/Change Due to Qualifying Event		
<input type="checkbox"/> Open Enrollment		
Enrollee Classification		
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Hourly	<input type="checkbox"/> Certified
<input type="checkbox"/> Retired	<input type="checkbox"/> Salaried	<input type="checkbox"/> Classified
<input type="checkbox"/> Other _____		
COBRA (if applicable)		
<input type="checkbox"/> Termination		
<input type="checkbox"/> Reduction in Hours		
<input type="checkbox"/> Divorce/Legal Separation*		
<input type="checkbox"/> Widowed/Surviving Dependent*		
<input type="checkbox"/> Dependent Child No Longer Eligible*		
Indicate qualifying date: _____		
*If a dependent is enrolling under their own social security number, the <b>SSN currently enrolled under must be provided.</b>		

Dependent Information³							
Relationship	Dependent First Name (Last only if different from enrollee)	Dental/Vision	Add/Term	Date of Birth	Male/Female/Non-binary	Disabled⁴	Network Facility Number⁵
Spouse/Partner		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	

¹ DeltaCare USA is our closed network plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enrollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.

² Enrollees can change plans only during open enrollment or due to a qualifying status change.

³ Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. Primary enrollee must be enrolled in a coverage type in order to add dependents.

⁴ Additional documentation, in the form of a doctor's note, will be required for disabled status.

⁵ To be completed only when choosing DeltaCare USA. There is a maximum of three facilities per family.

## DENTAL AND VISION

☐ 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 during the annual open enrollment period unless 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 have been offered coverage by my employer, but at this time I wish to decline dental coverage for:

☐ Myself and my dependents      ☐ Spouse/Partner      ☐ Child(ren)

### Reason

Required only if employee waiving dental coverage — not required if waiving coverage for dependents only

- ☐ Other Group Coverage      Carrier Name \_\_\_\_\_ Group # \_\_\_\_\_  
☐ Medicare/Medicaid provided dental coverage  
☐ Individual Policy  
☐ Other Reason \_\_\_\_\_ (explanation required)

☐ I have been offered coverage by my employer, but at this time I wish to decline vision coverage for:

☐ Myself and my dependents      ☐ Spouse/Partner      ☐ Child(ren)

### Reason

Required only if employee waiving vision coverage — not required if waiving coverage for dependents only

- ☐ Other Group Coverage      Carrier Name \_\_\_\_\_ Group # \_\_\_\_\_  
☐ Medicare/Medicaid provided vision coverage  
☐ Individual Policy  
☐ Other Reason \_\_\_\_\_ (explanation required)

*Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

Signature of Enrollee \_\_\_\_\_ Date \_\_\_\_\_