



ENROLLMENT/CHANGE FORM - CA

Delta Dental of California
Small Business Program
Combined Dental/Vision - PPO Only

VERY IMPORTANT - Please Print Legibly

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	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			
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		

- ☐ Add/Term/Change Due to Qualifying Event
- ☐ Open Enrollment

Enrollee Classification

- ☐ Full-Time ☐ Hourly ☐ Certified
- ☐ Retired ☐ Salaried ☐ Classified
- ☐ 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 their own social security number, the **SSN currently enrolled under must be provided.**

Dependent Information¹

Relationship	Dependent First Name (Last only if different from enrollee)	Dental/Vision	Add/Term	Date of Birth	Male/Female/Non-Binary	Disabled ²
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 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.

² Additional documentation, in the form of a doctor's note, will be required for disabled status.

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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)

Signature of Enrollee _____ Date _____