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
☐ COBRAenrollment

☐ 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 Partnership
☐ Divorced ☐ Separated

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: ______

Dependent Information:

Spouse/domestic partner

Name (Last, First, MI)	Code*	Spouse's SSN	Date of birth	E-mail	Marriage/Divorce date	M	F
						☐	☐

Child(ren):

Name (Last, First, MI)	Code*	Spouse's SSN	Date of birth	E-mail	If 19 or older, indicate: Full-time student	Disabled	M	F
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

For DeltaCare USA enrollees only:

Dental office name / Network Facility Name	Dental office ID code / Network Facility Number

Dental office name	Dental office ID code

**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:** ______