



ENROLLMENT/CHANGE FORM - CA

DUAL CHOICE

Delta Dental of California

www.deltadentalins.com

Select a Plan: **Fee-For-Service PPO** OR **DeltaCare® USA¹**
 Fee-For-Service: P.O. Box 429086, San Francisco, CA 94142-9086
 DeltaCare USA: P.O. Box 1803, Alpharetta, GA 30023

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY		
Group No.	Division	State
Effective Date	/ /	Hire Date / /
Name of Employer Corona-Norco Unified School		
Location	Pay Code	Benefit Package
Enrollee Classification		
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Hourly	<input type="checkbox"/> Certified
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Salaried	<input type="checkbox"/> Classified
<input type="checkbox"/> Retired	<input type="checkbox"/> Member/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 his/her social security number, the SSN currently enrolled under must be provided.		

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 Plans*	

Change Dental Plan*
<input type="checkbox"/> Fee-For-Service - Cancel
<input type="checkbox"/> DeltaCare USA - Cancel

*Enrollees can change plans only during open enrollment or due to a qualifying status change unless allowed by the group contract.

Primary Enrollee Information					
Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status	
/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single	<input type="checkbox"/> 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 <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/>			
Network Facility Name (DeltaCare USA only)	Network Facility Number (DeltaCare USA only)				
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	

Dependent Information								
Relationship	Dependent First Name (last name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled***	Name of School (coverage student)***	Network Facility Number † (DeltaCare USA only)
Spouse/Partner		<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"/>		
Dependent		<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"/>		

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. †Maximum of three facilities per family.

<input type="checkbox"/> 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.
<input type="checkbox"/> I decline coverage at this time.
Signature of Enrollee _____ Date _____ / /

¹DeltaCare USA is our prepaid 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.