DELTA DENTAL*     ENROLLMENT/CHANGE FORM - CA     DUAL CHOICE     Delta Dental of California														Group N Effectiv		Divi	USE sion Hire	ONLY State		
www.deltadentalins.com Select a Plan:			F	Fee-Fo	429086	5	_	OR		DeltaCare P.O. Box 1803		1803	03			/ f Employer	1	Date	/ /	
VERY IMPORTANT - Please Print Legibly San Francisco, CA 94142-9086 Alpharetta, GA 30023														Location		Pay Cod	÷	Benefit Packag	le	
Enrollee/Change Information Change Dental Plan*														*		Enrolle	e Clas	sifica	tion	
Add/Delete Dependent	dd/Delete Dependent     Image: Contraction of the previous II       arital Status Change     Change Dental Plans*						rollee ID Number Correction or ID under which benefits are received						rvice - Can JSA - Canc		Image: Full-Time       Image: Hourly       Image: Certified         Image: Part-Time       Image: Salaried       Image: Classified         Image: Part-Time       Image: Salaried					
*Enrollees can change plans only	during open enrollment or o							up contra ct		_							_			_
Social Security Number         Enrollee ID Number (if applicable)         Date of Birth         Gender											1	Marital	Status			COB	RA (if a	applical	ole)	
First Name									Fema	ale					<ul> <li>Termination</li> <li>Reduction in Hours</li> </ul>					
Mailing Address (Street) City								State Zip Code							Divorce/Legal Separation**					
E-mail Address (internal use only) Phone Number								-	- Phone Type - Cell Q Work Q Home Q						<ul> <li>Widowed/Surviving Dependent**</li> <li>Dependent Child No Longer Eligible**</li> </ul>					
Network Facility Name (DeltaCare USA only)         Name of Other Dental Carrier         Policy Holder Name (first/last)								twork Facility Number (DeltaCare USA only) Date of Birth / /							Indicate qualifying date: / / **If a dependent is enrolling under his/her social security number, the SSN currently enrolled					
Effective Date         Policy Holder Street Address           of Other Policy         /						City					State Zip Code					nust be pi		incitity	chioneu	
						Depen	dent l	nforma	tion	1										
	dent First Name	Add /	Term	Soc	al Secu	rity Number		e of Birth	-	Male / Female Studer			ent / Disabled***		Name o	f School student)***	Ne		cility Number e USA only)	ŧ
(last name only if different from enrollee) Spouse/Partner							/	/							(overage	siddenij			e usk uniy)	
Dependent							/	/												
Dependent							/	/												
Dependent							/	/												
Please attach a separate sheet for a	additional dependent inforr	mation.	All de	ependents	listed w	ill be considered	enrolled.	***Addi tiona	al docu	umer	ntation v	will be re	quired for disal	oled an	d student s	t atus. ‡Ma	ximum of t	hree faci	lities per fami	ily.
<ul> <li>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.</li> <li>I decline coverage at this time.</li> </ul>												s								
Signature of Enrollee       Date       /       /																				

<sup>1</sup>DeltaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enr ollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.