# ENROLLMENT/CHANGE FORM
# DUAL CHOICE

deltadentalins.com

**Select a Plan:** ❑ **Fee-For-Service** **OR** ❑ **DeltaCare® USA**[1]

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

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 | | |
| Location | Pay Code | Benefit Package |

## Enrollee/Change Information

❑ New Enrollment
❑ Add/Delete Dependent
❑ Marital Status Change
❑ Address Change
❑ Terminate Enrollee Coverage
❑ Change Dental Plans*
❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

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

## Change Dental Plan*

❑ **Fee-For-Service - Cancel**
❑ **DeltaCare USA - Cancel**

## Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified
❑ Part-Time ❑ Salaried ❑ Classified
❑ Retired ❑ Member/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 his/her social security number, the **SSN currently enrolled under must be provided.**

## Primary Enrollee Information

| Social Security Number | Enrollee ID Number (if applicable) | Date of Birth | Gender | Marital Status |
|---|---|---|---|---|
| | | / / | ❑ Male ❑ Female | ❑ Single ❑ 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 ❑ Work ❑ Home ❑ |

| 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 (overage student)*** | Network Facility Number ‡ (DeltaCare USA only) |
|---|---|---|---|---|---|---|---|---|
| Spouse | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | | |

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. ***Addi tional documentation will be required for disabled and student st atus. ‡Maximum of three facilities per family.

❑ 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 decline coverage at this time.

Signature of Enrollee _____ Date ____/____/____

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

**IMPORTANT**: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-XXX-XXX-XXXX.

**IMPORTANTE:** ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-XXX-XXX-XXXX. (Spanish)

**重要通知**：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。
這封信也可以用您所講的語言書寫。如需幫助，請立即撥打登列在您的Delta Dental ID卡背面上的會員/客戶服務部的電話，或者撥打電話 1-XXX-XXX-XXXX。(Chinese)