



ENROLLMENT/CHANGE FORM DUAL CHOICE

Delta Dental of California

VERY IMPORTANT - Please Print Legibly

Select a Plan: Delta Dental PPO OR DeltaCare® USA(DHMO)¹

COUNTY RETIREE: www.deltadentalins.com/countyofsantabarbara OR COURT RETIREE: www.deltadentalins.com/superiorcourtofctyofsantabarbara

Enrollee/Change Information

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

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

Change Dental Plan*

- Delta Dental PPO - Cancel
 DeltaCare USA - Cancel

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <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

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

Enrollee Classificationx

- COUNTY RETIREE
 SUPERIOR COURT RETIREE

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.

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/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.

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.

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.