DELTA DENTAL

SBCERS
Santa Barbara County Employees' Retirement System

# 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
- ☐ 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*

- ☐ **Delta Dental PPO - Cancel**
- ☐ **DeltaCare USA - Cancel**

## 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 RETIRE

## 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 ☐ Non-Binary | ☐ Single ☐ Married |

| First Name | Last Name | Middle Initial |
|---|---|---|
| | | |

| Mailing Address (Street) | City | State | Zip Code |
|---|---|---|---|
| asdfasdf | | | |

| 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 / Non-Binary | Student / Disabled*** | Name of School (overage student)*** | Network Facility Number ‡ (DeltaCare USA only) |
|---|---|---|---|---|---|---|---|---|
| Spouse/Partner | | ☐ ☐ | | / / | ☐ ☐ ☐ | ☐ ☐ | | |
| 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 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 ____/____/____

[1]DeltaCare 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.