DELTA DENTAL

California Dual-Choice Enrollment Form

Please select one of the following dental plans:

Fee-for-service plan

☐ Delta Dental PPO

For internal use only — fee-for-service
Group/Employer number:
ID number:
Effective date:

Prepaid DHMO plan:

☐ DeltaCare® USA

You must select a network dentist for this plan

Dental office name: _____

Office number ID code (required): _____

For internal use only — prepaid
Group/Employer number:
ID number:
Effective date:

Date Employed: _____

Employee Classification:
☐ Full-time
☐ Part-time
☐ Salaried
☐ Hourly
☐ Certificated
☐ Classified
☐ Retired
☐ COBRA

Group Division Number: 3273-1003 Group Name: LAPPL

Primary Enrollee Information:

Name: _____

Address: _____

City, state & ZIP: _____

Home phone number: (___) _____

E-mail address: _____

Date of birth: ___/___/___ ☐ Male ☐ Female

Social security number: _____

Network Facility Name (Delta Use Only) _____

Network Facility Number (Delta Use Only) _____

Action Requested:

☐ New enrollment
☐ Add dependent
☐ Remove dependent
☐ Name change
☐ Address change
☐ Social security number correction
☐ COBRAenrollment

Marital Status:

☐ Single ☐ Married ☐ Domestic Partnership
☐ Divorced ☐ Separated

Do you have dependent children?
☐ Yes ☐ No

Does your spouse have a dental plan?
☐ Yes ☐ No

Who is covered by spouse?
☐ Yourself ☐ Spouse ☐ Dependent children

If Delta Dental, indicate group number:

_____

Dependent Information:

Spouse/domestic partner

Name (Last, First, MI)	Code*	SSN	Date of birth	Marriage/Divorce date	M	F
					☐	☐

Child(ren):

Name (Last, First, MI)	Code*	SSN	Date of birth	If 19 or older, indicate: Full-time student	Disabled	M	F
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Relationship Codes: Spouse – SP Domestic Partner – DP Child – CH Child of DP – CD Other Adult – OA Other Child – OC

For DeltaCare USA enrollees only:

Dental office name
Network Facility Name

Dental office ID code
Network Facility Number

Dental office name

Dental office ID code

I understand that I may be required by the employer to pay for these benefits and those for my dependents. I agree to continue membership in the program selected above during employment and while the program is in force, I agree to comply with the terms of the group contract.

Enrollee Signature: _____ Date: _____