DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Orthodontic Benefits 2024
Adults & Dependent Children

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

☐ **Single $ 57.20** ☐ **2-Party $ 108.68** ☐ **Family $ 165.87**

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
7006	1000 & 1001	CA

Effective Date / / Hire Date / /

Name of Employer: NATOMAS UNIFIED SD

Location | Pay Code | Benefit Package

Enrollee/Change Information

☐ New Enrollment ☐ Marital Status Change ☐ Terminate Enrollee Coverage ☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

☐ Add/Delete Dependent ☐ Address Change ☐ Other _____

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 ☐

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

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**.

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse/Partner		☐ ☐		/ /	☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐	

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.

☐ 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 ____/____/____

Form 3400 CA

To cover a spouse or domestic partner, provide a copy of your marriage certificate or declaration of domestic partnership, along with a copy of the 1st page of most recent tax return

To cover a dependent up to age 26, provide a copy of your dependent's birth certificate, adoption paperwork or other supporting documentation.

$2,000 Lifetime Maximum Orthodontic Coverage - Adults & Dependents