



DUAL CHOICE ENROLLMENT/CHANGE FORM

For Employer Use Only

Select a program: Delta Dental DeltaCare® USA*
(Not available in all areas)

Effective Date / /	Group No.
Full Time Hire Date / /	Sublocation

Delta Dental Insurance Company

*DeltaCare® USA is administered by Delta Dental Insurance Company.

Check One

(**Enrollees can change plans only during open enrollment)

- New Hire
- Open Enrollment
- Change Dental Plans**
- COBRA
- Add/Delete Dependent
- Terminate Employee Coverage
- Spouse Employment Change
- Marital Change
- Other _____

Indicate qualifying date:

/ /	/ /	/ /
(Month)	(Day)	(Year)

COBRA Enrollment Only

Please indicate qualifying event:

- Termination
- Reduction in Hours
- Divorce
- Widowed/Surviving Dependent
- Dependent Child No Longer Eligible

Indicate qualifying date:

/ /	/ /	/ /
(Month)	(Day)	(Year)

- Delta Dental - CANCEL**
- DeltaCare® USA - CANCEL**

Delta Dental - 1-800-521-2651
DeltaCare® USA - 1-800-422-4234

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____
(Last, First, Middle)

Mailing Address: _____
(Street Address)

/ /	/ /	/ /	/ / /
(City)	(State)	(Zip)	(Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. _____ Date of Birth: _____
(Month) (Day) (Year)

Name of Employer/Group _____ Location _____

Marital Status: Single Married Gender: Male Female Phone # (____) _____ - _____

Do you have dependent children? Yes No Are you or your dependents covered under another dental plan? Yes No

Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth:		
Spouse: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	/ /
					(Month)	(Day)	(Year)
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	/ /
					(Month)	(Day)	(Year)
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	/ /
					(Month)	(Day)	(Year)
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	/ /
					(Month)	(Day)	(Year)
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	/ /
					(Month)	(Day)	(Year)
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	/ /
					(Month)	(Day)	(Year)
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	/ /
					(Month)	(Day)	(Year)

DeltaCare® USA

Dentist Name: _____ Provider # _____ Location (State) _____

- I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.
- I decline coverage at this time.

Notice for Florida only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee _____

Date _____