DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

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

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
3676/1047	**NONSAFETY**	**CA**

Effective Date	Hire Date
/ /	/ /

Name of Employer **CITY OF MANTECA**

Location	Pay Code	Benefit Package

Enrollee Classification

D Full-Time D Hourly D Certified
D Part-Time D Salaried D Classified
D Retired D Member/Other _____

COBRA (if applicable)

D Termination
D Reduction in Hours
D Divorce/Legal Separation*
D Widowed/Surviving Dependent*
D 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
		/ /	D Male D Female	D Single D 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 D Work D Home D

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

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.

D 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.

D I decline coverage at this time.

Signature of Enrollee _____ Date / /