DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Small Business Program

Combined Dental/Vision - PPO Only

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
		CA

Effective Date	Hire Date

Name of Employer: Notre Dame De Namur University

❑ Add/Term/Change Due to Qualifying Event

❑ Open Enrollment

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	Date of Birth	Gender ❑ Male ❑ Female ❑ Non-binary	Marital Status ❑ Single ❑ Married
First Name		Last Name	Middle
Mailing Address (Street)		City	State / Zip
E-mail Address (internal use only)		Phone Number	Phone Type ❑ Cell ❑ Work ❑ Home
Coverage type ❑ Dental ❑ Vision			
Name(s) of Other Dental Carrier and/or Vision Carrier		Policy Holder Name (first/last)	Date of Birth
Effective Date(s) of Other Policies	Policy Holder Street Address	City / State	Zip

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified

❑ Retired ❑ Salaried ❑ Classified

❑ 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 their own social security number, the **SSN currently enrolled under must be provided**.

Dependent Information[1]

Relationship	Dependent First Name (Last only if different from enrollee)	Dental/Vision	Add/Term	Date of Birth	Male/Female/Non-Binary	Disabled[2]
Spouse/Partner		❑ ❑	❑ ❑		❑ ❑ ❑	❑
Dependent		❑ ❑	❑ ❑		❑ ❑ ❑	❑
Dependent		❑ ❑	❑ ❑		❑ ❑ ❑	❑
Dependent		❑ ❑	❑ ❑		❑ ❑ ❑	❑
Dependent		❑ ❑	❑ ❑		❑ ❑ ❑	❑

[1] Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. Primary enrollee must be enrolled in a coverage type in order to add dependents.

[2] Additional documentation, in the form of a doctor's note, will be required for disabled status.

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DENTAL AND VISION

❑ 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 during the annual open enrollment period unless 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 have been offered coverage by my employer, but at this time I wish to decline dental coverage for:

❑ Myself and my dependents ❑ Spouse/Partner ❑ Child(ren)

Reason

Required only if employee waiving dental coverage — not required if waiving coverage for dependents only

❑ Other Group Coverage Carrier Name _____ Group #_____
❑ Medicare/Medicaid provided dental coverage
❑ Individual Policy
❑ Other Reason _____ (explanation required)

❑ I have been offered coverage by my employer, but at this time I wish to decline vision coverage for:

❑ Myself and my dependents ❑ Spouse/Partner ❑ Child(ren)

Reason

Required only if employee waiving vision coverage — not required if waiving coverage for dependents only

❑ Other Group Coverage Carrier Name _____ Group #_____
❑ Medicare/Medicaid provided vision coverage
❑ Individual Policy
❑ Other Reason _____ (explanation required)

Signature of Enrollee _____ Date _____