



# ENROLLMENT/CHANGE FORM - CA DUAL CHOICE

Delta Dental of California

deltadentalins.com

**VERY IMPORTANT - Please Print Legibly**

Enrollee/Change Information		
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Address Change	<input type="checkbox"/> SSN/Enrollee ID Number Correction or previous ID under which benefits are received
<input type="checkbox"/> Add/Delete Dependent	<input type="checkbox"/> Terminate Enrollee Coverage	
<input type="checkbox"/> Marital Status Change	<input type="checkbox"/> Change Dental Plans*	

\*Enrollees can change plans only during open enrollment or due to a qualifying status change unless allowed by the group contract.

Primary Enrollee Information					
Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status	
		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> 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 <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/>		
Network Facility Name (DeltaCare USA only)			Network Facility Number (DeltaCare USA only)		
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

FOR GROUP USE ONLY		
Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package
Enrollee Classification		
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Hourly	<input type="checkbox"/> Certified
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Salaried	<input type="checkbox"/> Classified
<input type="checkbox"/> Retired	<input type="checkbox"/> Member/Other _____	
COBRA (if applicable)		
<input type="checkbox"/> Termination		
<input type="checkbox"/> Reduction in Hours		
<input type="checkbox"/> Divorce/Legal Separation**		
<input type="checkbox"/> Widowed/Surviving Dependent**		
<input type="checkbox"/> Dependent Child No Longer Eligible**		
Indicate qualifying date: / /		
**If a dependent is enrolling under his/her social security number, the <b>SSN currently enrolled under must be provided.</b>		

Dependent Information								
Relationship	Dependent First Name (last name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled***	Name of School (overage student)***	Network Facility Number † (DeltaCare USA only)
Spouse/Partner		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		

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. †Maximum of three facilities per family.

<input type="checkbox"/>	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.
<input type="checkbox"/>	I decline coverage at this time.
Signature of Enrollee _____ Date / /	

<sup>1</sup>DeltaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enrollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.

# Keep Smiling

## Delta Dental PPO<sup>SM</sup>



### Save with PPO

Visit a dentist in the PPO<sup>1</sup> network to maximize your savings.<sup>2</sup> These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.<sup>3</sup> Find a PPO dentist at [deltadentalins.com](http://deltadentalins.com).<sup>4</sup>

### Set up an online account

Get information about your plan anytime, anywhere by signing up for an Online Services account at [deltadentalins.com](http://deltadentalins.com). This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

### Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your

plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button.

### Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

### Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.<sup>5</sup> You can find this date by logging in to Online Services.

### Newly covered?

Visit [deltadentalins.com/welcome](http://deltadentalins.com/welcome).

## Save with a PPO dentist



<sup>1</sup> In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

<sup>2</sup> You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

<sup>3</sup> You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

<sup>4</sup> We recommend verifying before each appointment that your dentist is a PPO dentist.

<sup>5</sup> Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

**LEGAL NOTICES:** Access federal and state legal notices related to your plan at [deltadentalins.com/about/legal/index-enrollee.html](http://deltadentalins.com/about/legal/index-enrollee.html).

**Plan Benefit Highlights for:** Del Mar Union School District  
**Group No:** 07028 - 01104

In this incentive plan, Delta Dental pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

**DELTA DENTAL PPO<sup>SM</sup>**

**BENEFIT HIGHLIGHTS**

<b>Eligibility</b>	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age 25			
<b>Deductibles</b>	\$25 per person each calendar year			
Deductibles waived for Diagnostic & Preventative (D & P)?	No			
<b>Maximums</b>	\$2,500 per person each calendar year			
D & P counts toward maximum?	Yes			
<b>Waiting Period(s)</b>	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

<b>Benefits and Covered Services*</b>	<b>Delta Dental PPO dentists**</b>	<b>Non-Delta Dental PPO dentists**</b>
<b>Diagnostic &amp; Preventive Services (D &amp; P)</b> Exams, cleanings and x-rays	70-100 %	70-100 %
<b>Basic Services</b> Fillings, composites and sealants	70-100 %	70-100 %
<b>Endodontics</b> (root canals)	70-100 %	70-100 %
<b>Periodontics</b> (gum treatment)	70-100 %	70-100 %
<b>Oral Surgery</b>	70-100 %	70-100 %
<b>Major Services</b> Crowns, inlays, onlays and cast restorations	70-100 %	70-100 %
<b>Prosthodontics</b> Bridges, dentures and implants	60 %	50 %
<b>Orthodontic Benefits</b> Dependent children	50 %	50 %
<b>Orthodontic Maximum</b>	\$ 2,000 Lifetime	\$ 2,000 Lifetime
<b>Dental Accident Benefits</b>	100 % \$1,000 (Separate calendar year maximum)	

\* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.  
 \*\* Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California 100 First St. San Francisco, CA 94105	<b>Customer Service</b> 866-499-3001	<b>Claims Address</b> P.O. Box 997330 Sacramento, CA 95899-7330
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This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.