

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department

at: Fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – annual.

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: DeltaCare

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at:

Thank you for choosing...



Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703
(800) 422-4234

Broker #: _____

Applicant/Dependent Information

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

I understand that, if I have indicated that coverage under the Program is to be provided only for the dependent child(ren) named on this form, I am responsible for payment of the required annual Premium and compliance with all of the provisions and conditions of the Disclosure Form/Contract.

I understand that I must select a DeltaCare USA Contract Dentist from the list of dental facilities. If the selected facility is not available, non-contracted or closed to further enrollment, Delta Dental reserves the right to assign me to another dental office as close as possible to my home. In the event that Delta Dental cannot assign me to a Contract Dentist my premium will be refunded.

In accordance with the disclosure requirements of California Health & Safety Code Section 1363(h), this is to advise you that Delta Dental's ratio of health care expenses to premiums received for the last calendar year, with respect to the DeltaCare USA Individual/Family Dental Program, was 67.91%.

Name:	Last _____ First _____ MI _____		
Mailing Address:	Address _____		
	City _____		State _____ Zip _____
Date of Birth:	Month _____ Day _____ Year _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone # _____
SSN/ID #:	_____	E-mail _____	For internal use only _____
Contract Facility Name:	_____		Contract Facility # _____

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF			
Relationship Code*	Dependent Name	Male/ Female	Date of Birth
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____/____/____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____/____/____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____/____/____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____/____/____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____/____/____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____/____/____

* Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:
Spouse - SP Domestic Partner - DP Child - CH Other Child - OC

PROGRAM COST AND PAYMENT OPTION (choose only one)

Check appropriate box based on the information below:

- | | | |
|--|------------|-----------------|
| <input type="checkbox"/> Individual annual Premium | Plan CAA54 | \$ 91.80 |
| <input type="checkbox"/> Individual plus one dependent annual Premium | | \$148.53 |
| <input type="checkbox"/> Individual plus two or more dependents annual Premium | | \$217.56 |
| One-time non refundable Enrollment Fee (required for new enrollment) | | \$ 10.00 |
| TOTAL | | \$ _____ |

Indicate effective date: _____
Month Day Year

This Enrollment and Payment Authorization Form and your check or money order, if applicable, must be received by the 21st day of the month for your coverage to be effective on the first day of the following month.

I wish to enroll in the DeltaCare USA Individual/Family Dental Program. I acknowledge that I have read the Disclosure Form/Contract and understand that coverage under the Program is subject to the terms as described in the Disclosure Form/Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of Delta Dental, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with the Delta Dental provider agreements or local, state or federal laws. This authorization is valid for the duration of coverage.

Signature: _____ Date _____

Return form to Delta Dental of California at Dept. 0170, Los Angeles, CA 90084-0170. For assistance, call our Customer Service department at 800-422-4234.

PAYMENT OPTIONS

- CHECK/MONEY ORDER PAYMENT OPTION
Please make check or money order payable to Delta Dental of California.

You will have the opportunity to renew prior to the end of the Contract Term to avoid interruption of coverage.

- CREDIT CARD PAYMENT OPTION
 VISA MASTERCARD DISCOVER AMERICAN EXPRESS

CARD # _____

EXPIRATION DATE _____

NAME AS IT APPEARS ON THE CARD _____

SIGNATURE _____

DATE _____

By signing above you authorize Delta Dental of California to charge your credit card account for the cost of the DeltaCare USA Program.

Note: Any credit card refunds under the Program may be made by check or credit card.