

# 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...



Broker #: \_\_\_\_\_

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

**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:

- |                          |  |
|--------------------------|--|
|                          | Plan CAA55   |
| <input type="checkbox"/> | Individual annual Premium <b>\$ 80.76</b>  |
| <input type="checkbox"/> | Individual plus one dependent annual Premium <b>\$130.68</b>                         |
| <input type="checkbox"/> | Individual plus two or more dependents annual Premium <b>\$191.16</b>                |
|                          | One-time non refundable Enrollment Fee (required for new enrollment) <b>\$ 10.00</b> |
| <b>TOTAL</b>             | <b>\$ 10.00</b>  |

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 21<sup>st</sup> 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 \_\_\_\_\_

**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.