COBRA ENROLLMENT CHANGE FORM – CSU
Delta Dental of California

Select a Plan: ☐ Delta Dental PPO™ or ☐ DeltaCare® USA[1]

Reason establishing COBRA eligibility

18 Months Coverage:	29 Months Coverage:	36 Months Coverage:
☐ Reduction of Work Hours ☐ Termination of Employment Check one below: ☐ Voluntary Termination ☐ Involuntary Termination	☐ Social Security Disabled	☐ Legal Separation or Divorce ☐ Dependent Ceasing to be Eligible ☐ Death of Subscriber Please give primary members information Name ____________________ SS#____________________

Enrollee/Change Information

Effective date: ____________________

- ☐ New Enrollment
- ☐ Add/Delete Dependent
- ☐ Marital Status Change
- ☐ Address Change
- ☐ Terminate Enrollee Coverage
- ☐ Change Dental Plans[2]
- ☐ Cancel COBRA enrollment

☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received: ____

Change Dental Plans[2]

(Check only one)

☐ **Delta Dental PPO**

☐ **DeltaCare USA**

[1] 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 and must reside in California.

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

deltadentalins.com/csu

Current Enrollment — to be completed by employer

☐ AEI Eligible

Group Number:	Division:	State:
Name of Employer: **CSU**	Campus Contact Name:	Phone Number:

Primary Enrollee Information

Social Security Number:	Enrollee ID Number (if applicable):	Date of Birth:

Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Registered Domestic Partner

First Name:	Last Name:	Middle Initial:

Mailing Address (Street):	City:	State:	Zip Code:

E-mail Address (internal use only):	Phone Number:	Phone Type: ☐ Cell ☐ Work ☐ Home

Network Facility Name (DeltaCare USA only):	Network Facility Number (DeltaCare USA only):

Name of Other Dental Carrier (if applicable):	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 name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Disabled[3]	Date New Dependent Acquired	Network Facility Number (DeltaCare USA only)
Spouse/ Registered Domestic Partner		☐ Add ☐ Term			☐ Male ☐ Female	☐ Yes ☐ No		
Dependent		☐ Add ☐ Term			☐ Male ☐ Female	☐ Yes ☐ No		
Dependent		☐ Add ☐ Term			☐ Male ☐ Female	☐ Yes ☐ No		
Dependent		☐ Add ☐ Term			☐ Male ☐ Female	☐ Yes ☐ No		

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled.

☐ I authorize the above changes to my existing COBRA enrollment. 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 during open enrollment.

Signature of Enrollee:	Date:

Please mail form to: Delta Dental, P.O. Box 537011, Sacramento, CA 95853-7011

[3] Additional documentation will be required for disabled status.