COBRA ENROLLMENT CHANGE FORM   CSU

Delta Dental of California

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

C rrent Enrollment — to be completed by employer

☐ AEI Eligible

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

Primar 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:

E ective Date of Other Policy:

Policy Holder Street Address:	City:	State:	Zip Code:

Dependent Information

Relationship	Dependent First Name (last name only if di erent from enrollee)	Add / Term	Social Sec rit N mber	Date of Birth	Male / Female	Disabled	Date Ne Dependent Acq ired	Net ork Facilit N mber (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:

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3 Additional documentation will be required for disabled status.