DeltaCare® USA

Quality Care for You and Your Family

Disclosure Form/Contract

Provided by:
Delta Dental of California
17871 Park Plaza Drive,
Suite 200
Cerritos, CA 90703

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234
deltadentalins.com

DeltaCare® USA

DeltaCare USA INDIVIDUAL/FAMILY DENTAL PROGRAM CAA54
ENROLLMENT AND PAYMENT AUTHORIZATION FORM

Broker #: 4378

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

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 Dentalís ratio of health care expense to premiums received for the last calendar year, with respect to the DeltaCare USA Individual/Family Dental Program, was 67.91%.

Applicant/Dependent Information

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

Name: Last First MI

Mailing Address: Address

City State Zip

Date of Birth: Month Day Year

❑ Male
❑ Female

Home Phone #

SSN/ID #:

E-mail

For internal use only

Contract Facility Name:

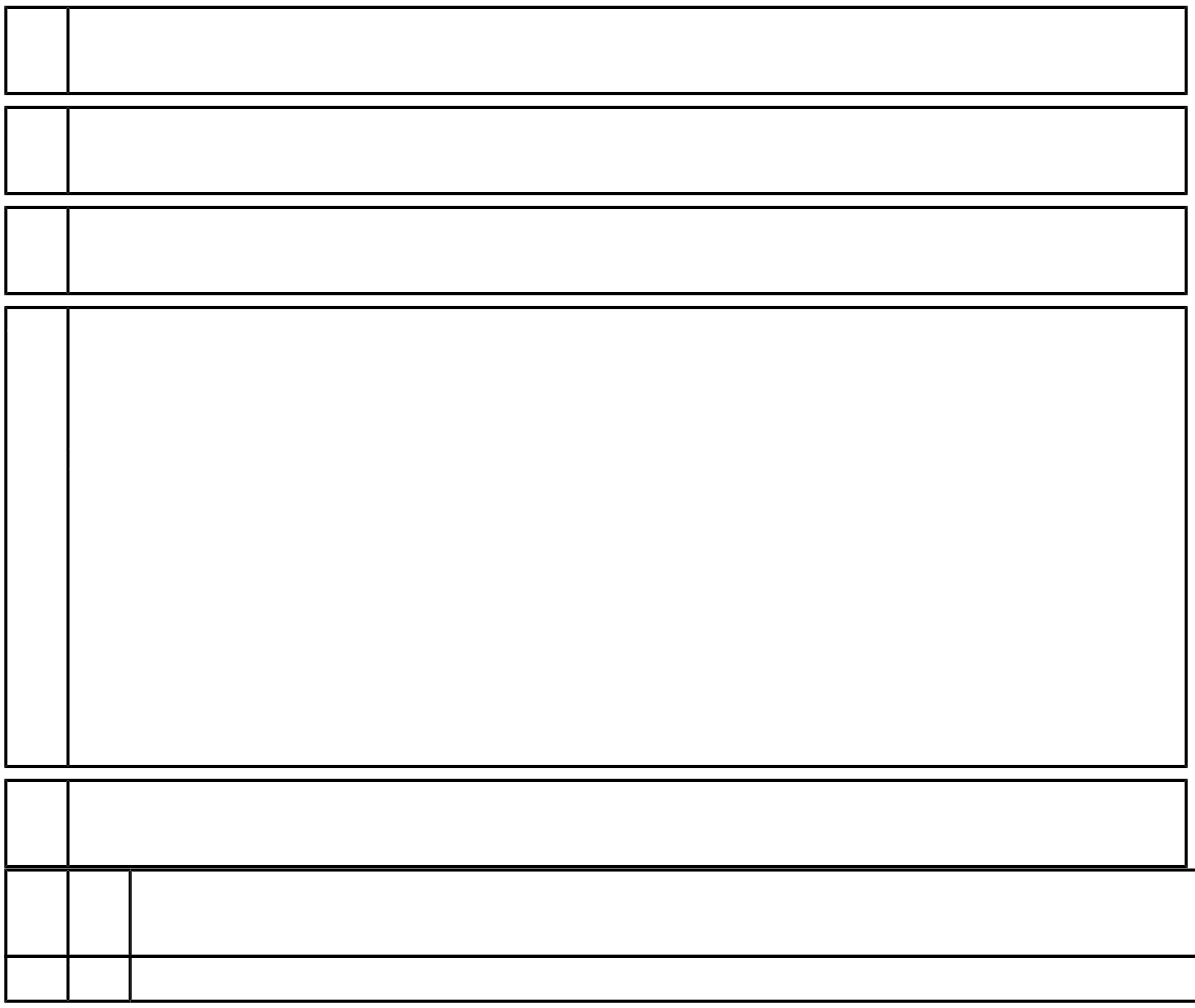
Contract Facility #

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Male/ Female	Date of Birth
		❑ ❑	
		❑ ❑	
		❑ ❑	
		❑ ❑	
		❑ ❑	
		❑ ❑	

* 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**



If you have any questions or need additional information, call or write:

■ **Delta Dental Insurance Company**
P.O. Box 1803
Alpharetta, GA 30023
800-422-4234

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 1-800-422-4234. You may also be able to receive this document in Spanish or Chinese.

IMPORTANTE: ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 1-800-422-4234. También puede recibir este documento en español o chino.

重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。 如需免費協助，請電 Delta Dental 1-800-422-4234 您也能取得這份文件的西班牙文或中文譯本。

In California, DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.