DeltaCare® USA

ENROLLMENT/CHANGE FORM

Check One

- ☐ New Enrollment
- ☐ Name Change
- ☐ COBRA
- ☐ New Social Security Number/ Employee ID Number
- ☐ Address Change
- ☐ Add Dependent
- ☐ Remove Dependent

Indicate effective date of change:
*(Does not pertain to facility change)

(Month)   (Day)   (Year)

COBRA Enrollment Only

Please indicate qualifying event:
- ☐ Termination
- ☐ Widowed
- ☐ Surviving Dependent
- ☐ Divorce
- ☐ Overage Dependent

Indicate qualifying date:

(Month)   (Day)   (Year)

Primary Enrollee Information   VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____ (Last) _____ (First) _____ (M.I.)

Mailing Address: _____ (Street Address)

_____ (City) _____ (State) _____ (Zip Code)

E-mail Address: _____

Date of Birth: ____ (Month) ____ (Day) ____ (Year)   Male ☐   Female ☐   Home Phone #: (____) ____ — ____

Name of Employer/Group: _____

Location: _____

Soc. Security #: ____ — ____ — ____   Employee Identification #: _____

Contract Facility Name: _____   Contract Facility #: _____

Dependent Information   VERY IMPORTANT - PLEASE PRINT LEGIBLY   (To add additional dependents, please attach a separate sheet.)   Note: You may choose up to three separate offices for yourself and all dependent enrollees.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Male/Female (Check One) M F	Date of Birth (Month) (Day) (Year)	Contract Facility Name	Contract Facility #:
		☐ ☐			
		☐ ☐			
		☐ ☐			
		☐ ☐			
		☐ ☐			
		☐ ☐			
		☐ ☐			

*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   Child of DP - CD   Other Adult - OA   Other Child - OC

Signature of Primary Enrollee _____   Date _____