DELTACARE®

ENROLLMENT/CHANGE FORM

FOR EMPLOYER USE ONLY

Group No. _____

Contract Type _____

Effective Date _____

Check One

- ○ New Enrollment
- ○ Name Change
- ○ Facility 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)

COBRA Enrollment Only

Please indicate qualifying event:

- ○ Termination
- ○ Widowed
- ○ Surviving Dependent
- ○ Divorce
- ○ Overage Dependent

Indicate qualifying date:

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)

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 _____