DeltaCare USA

ENROLLMENT/CHANGE FORM

FOR EMPLOYER USE ONLY	
Group No.	-
Contract Type	-
Effective Date	_/

		Effec	tive Date	
Check One	Primary Enrollee Information	VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box	x between each word)	
 New Enrollment Name Change Facility Change* COBRA New Social Security Number/ Employee ID Number Address Change Add Dependent 	Name: (Last) Mailing Address: (Street Address)	VERT INFORTAGE TRACE COST (First)	(M.I.)	
Remove Dependent	(oreer names)			
Indicate effective date of change: *(Does not pertain to facility change)	E-mail Address:	(State) (ZIpCone)		
(Month) (Day) (Year)	Date of Birth: (Month) (Day)	Male ☐ Home Female ☐ Phone #: (☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
COBRA Enrollment Only	Name of Employer/Group:			
Please indicate qualifying event: Termination Widowed Surviving Dependent Overage Dependent	Location: Soc. Security #:	Employee Identification #:	Contract	
Indicate qualifying date:	Contract Facility Name:		Facility #: Land American Facility #: Land A	
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				
F	PLEASE LIST ELIGIBLE DEPENDENTS TO BE C	COVERED IN ADDITION TO YOURSELF		
Relationship Basedon Name	PLEASE LISTELIGIBLE DEPENDENTS TO BE C Male/ Female Date of Birth	COVERED IN ADDITION TO YOURSELF Contract Facility Name	Contract Facility #:	
Relationship	Male/ Dependents to BE C	COVERED INADDITION TO YOURSELF		
Relationship Basedon Name	Male/ Female Date of Birth (Check One) (Month) (Day) (Year) M F	COVERED INADDITION TO YOURSELF		
Relationship	Male/ Female Date of Birth (Check One) (Month) (Day) (Year) M F	COVERED INADDITION TO YOURSELF		
Relationship	Male/ Female Date of Birth (Check One) (Month) (Day) (Year) M F	COVERED INADDITION TO YOURSELF		
Relationship	Male/ Female Date of Birth (Check One) (Month) (Day) (Year) M F Date of Birth	COVERED INADDITION TO YOURSELF		
Relationship Codes: Place the following two character codes:	Male/ Female Date of Birth (Check One) (Month) (Day) (Year) M F Date of Birth Date of Birth Date of Birth Date of Birth	COVERED INADDITION TO YOURSELF Contract Facility Name		
Relationship Code* Dependent Name Page 1	Male/ Female Date of Birth (Check One) (Month) (Day) (Year) M F Date of Birth	COVERED INADDITION TO YOURSELF Contract Facility Name		
Relationship Codes: Place the following two character codes:	Male/ Female Date of Birth (Check One) (Month) (Day) (Year) M F Date of Birth Date of Birth Date of Birth Date of Birth	COVERED INADDITION TO YOURSELF Contract Facility Name		