DELTACARE®
Dental HMO Program

FOR INTERNAL USE ONLY
Group No. _____
CoPower ID No. _____
Effective Date _____

ENROLLMENT/CHANGE FORM

ACTION REQUEST (Check all that apply)

☐ New Enrollment ☐ Address Change ☐ COBRA
☐ Add/Delete Dependent ☐ New Social Security Number ☐ Add/Delete Domestic Partner

EMPLOYEE INFORMATION

Employer Name: _____ Employer No. _____

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

Social Security No. _____ Date of Hire: _____

☐ Male ☐ Female Date of Birth: _____ Phone: __ _____ _____

Mailing Address: _____

_____

DEPENDENT INFORMATION

Spouse/Domestic Partner Name Last (if different) First	Add / Delete	**Sex** M F	**Birthdate** Month Day Year	**Date of Marriage** Month Day Year	
Child Name Last (if different) First	Add / Delete	**Sex** M F	**Birthdate** Month Day Year	**If child is 19 years or older** Full-time Student?*	Disabled?
				☐ Yes*	☐ Yes
				☐ Yes*	☐ Yes
				☐ Yes*	☐ Yes
				☐ Yes*	☐ Yes

***If yes, please provide proof of full-time student status**

DENTAL OFFICE CHOICE

Dental Office Number: _____ City: _____

Comments:

_____

_____

_____

_____

Employee Signature: **Date:**

Send this form to CoPower, 477 Ninth Avenue, Suite 102, San Mateo, CA 94402 or fax to (650) 348-1149

White Copy — CoPower Yellow Copy — Employer