



Delta Dental Plan of California

# Enrollment — Voluntary

Group Name \_\_\_\_\_

Delta Group/Division Number \_\_\_\_\_

**A ENROLLEE** (Complete this section for new enrollment or change of status)

<b>Name</b> Last _____ First _____ Middle Initial _____			<b>Social Security Number</b> _____-_____-_____ (Member I.D. Number)		<b>Date Employed</b> ____/____/____ Month Day Year		<b>Action Requested</b> <input type="checkbox"/> New enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Transfer <input type="checkbox"/> Change in enrollment <input type="checkbox"/> Rehire		<b>Please enroll me in the following:</b> <input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision			
<b>Birthdate</b> Month ____ Day ____ Year ____		<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		<b>Do you have dependent children?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who is covered: <input type="checkbox"/> yourself <input type="checkbox"/> spouse <input type="checkbox"/> dependent children If Delta Dental, indicate group number: _____			<b>Employee Classification</b> <input type="checkbox"/> Certificated <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Classified <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> Salaried <input type="checkbox"/> COBRA		

Mailing Address \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

<b>FOR DELTA USE ONLY</b>
<b>Effective Date of Coverage</b>
<b>Family Indicator Code</b>

**COBRA Enrollment**  
I understand that I may be required by the employer to pay for COBRA benefits

**Note:** If Dependent is enrolling under own social security number, the original Member's social security number must be supplied.

Benefits previously received under Social Security Number (Member I.D. Number) \_\_\_\_\_  
Qualifying Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**B Change to Existing Enrollment** (Complete all sections that apply)

Name change     Add new dependent     Delete dependent     Address change listed above

Reason for change \_\_\_\_\_ Effective date of change \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**C DEPENDENTS** (Complete for new enrollment or to add or delete dependents)

Spouse Name		Add/ Delete	Sex M F	Birthdate Month Day Year ____/____/____	Marriage/Divorce Date Month Day Year ____/____/____	Spouse's Social Security Number	
Last (if different)	First Middle Initial						
Child Name		Add/ Delete	Sex M F	Birthdate Month Day Year ____/____/____	If Child is 19 years or older (check one)		Child's Social Security Number
Last (if different)	First Middle Initial				Full-time Student	Disabled	

**D Signature** (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits. I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature \_\_\_\_\_ Date \_\_\_\_\_