



Delta Dental Plan of California

# Enrollment — Non Voluntary

Group Name

Delta Group/Division Number

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

<b>Name</b>			<b>Social Security Number</b>		<b>Date Employed</b>		<b>Action Requested</b>		<b>Please enroll me in the following:</b>		
Last First Middle Initial			_____-_____-_____ (Member I.D. Number)		____/____/____ Month Day Year		<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		<input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision		
<b>Birthdate</b>		<b>Sex</b>	<b>Marital Status</b>		<b>Do you have dependent children?</b>			<b>Employee Classification</b>			
Month Day Year		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		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: _____			<input type="checkbox"/> Certified <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 (_____) _____				<b>FOR DELTA USE ONLY</b>			
City _____ State _____ ZIP code _____							
<input type="checkbox"/> <b>COBRA Enrollment</b> I understand that I may be required by the employer to pay for COBRA benefits  <b>Note:</b> 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) _____						<b>Effective Date of Coverage</b>   <b>Family Indicator Code</b>	
				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 there is no contribution required by me for coverage of myself or my dependents. (Exception — See COBRA enrollment) 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 \_\_\_\_\_