



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)

Name Last _____ First _____ Middle Initial _____			Social Security Number _____-_____-_____ (Member I.D. Number)		Date Employed ____/____/____ Month Day Year		Action Requested <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		Please enroll me in the following: <input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision			
Birthdate Month ____ Day ____ Year ____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Do you have dependent children? <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: _____			Employee Classification <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 _____					
<input type="checkbox"/> 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.										FOR DELTA USE ONLY <hr/> Effective Date of Coverage <hr/> Family Indicator Code		
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 Last (if different)		First	Middle Initial	Add/Delete	Sex M F	Birthdate Month Day Year ____/____/____	Marriage/Divorce Date Month Day Year ____/____/____	Spouse's Social Security Number	
Child Name Last (if different)		First	Middle Initial	Add/Delete	Sex M F	Birthdate Month Day Year ____/____/____	If Child is 19 years or older (check one) <input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled		Child's Social Security Number

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 _____