DELTA DENTAL®

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)

Name

Last First Middle Initial

Social Security Number

(Member I.D. Number)

Date Employed

Month Day Year

Action Requested

☐ New enrollment ☐ Reinstatement
☐ COBRA enrollment ☐ Transfer
☐ Change in enrollment ☐ Rehire

Please enroll me in the following:

☐ Delta Dental
☐ Delta Vision

Birthdate

Month Day Year

Sex

☐ Male
☐ Female

Marital Status

☐ Single
☐ Married
☐ Divorced
☐ Separated

Do you have dependent children?

☐ Yes
☐ No

Does your spouse have a dental plan? ☐ Yes ☐ No

If yes, who is covered: ☐ yourself ☐ spouse ☐ dependent children

If Delta Dental, indicate group number: _____

Employee Classification

☐ Certificated ☐ Full-time ☐ Part-time
☐ Classified ☐ Hourly ☐ Retired
☐ Salaried ☐ COBRA

Mailing Address _____ Telephone Number (_____) _____

City _____ State _____ ZIP code _____

FOR DELTA USE ONLY

Effective Date of Coverage

Family Indicator Code

☐ **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 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)		**Child's Social Security Number**
				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 _____