



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 <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 _____ | | | FOR DELTA USE ONLY | | | | | | |
| <input type="checkbox"/> COBRA Enrollment I understand that I may be required by the employer to pay for COBRA benefits | | | | | | | Effective Date of Coverage | | | | | | | |
| 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 | | | | | | | | | | | | Family Indicator Code | | |

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 _____