



Delta Dental Plan of California

2020 Open Enrollment

Enrollment — Non Voluntary

Group Name _____

Delta Group/Division Number _____

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

Name			Social Security Number	Date Employed	Action Requested	Please enroll me in the following:
Last	First	Middle Initial	(Member I.D. Number)	Month / Day / Year	<input type="checkbox"/> New enrollment <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Change in enrollment	<input type="checkbox"/> Reinstatement <input type="checkbox"/> Transfer <input type="checkbox"/> Rehire <input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision

Birthdate	Sex	Marital Status	Do you have dependent children?	Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employee Classification
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	<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	<input type="checkbox"/> Certified <input type="checkbox"/> Classified <input type="checkbox"/> Salaried <input type="checkbox"/> Full-time <input type="checkbox"/> Hourly <input type="checkbox"/> COBRA <input type="checkbox"/> Part-time <input type="checkbox"/> Retired

Mailing Address _____ Telephone Number (_____) _____
 City _____ State _____ ZIP 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

FOR DELTA USE ONLY

Effective Date of Coverage

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 _____