



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			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"/> 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		
Birthdate		Sex	Marital Status		Do you have dependent children?			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		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 (____) _____					
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.											
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 _____