DELTA DENTAL®

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
☐ 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) **Full-time Student**	**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 _____