DELTA DENTAL®
Delta Dental Plan of California

Enrollment — Voluntary

Group Name
OXNARD UNION HIGH SCHOOL DISTRICT

Delta Group/Division Number
7011-

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 _____