RESIG
REDWOOD EMPIRE SCHOOLS' INSURANCE GROUP

DELTA DENTAL®
vsp vision care

Dental & Vision Enrollment/Change/Term Form

Section A: For District Office Use Only

District Name: _____ **Date of Hire:** _____ **Vision Group/Division:** _____

EE Classification: □ Classified □ Certificated □ Management/Confidental **Effective Date:** _____ **Dental Group/Division:** _____

Event: □ New Enrollment □ Terminate Coverage □ Transfer □ Add Dependent(s) □ Delete Dependent(s) □ Change of Address □ Update or Correct Name, DOB or SSN

Notes:

Section B: Enrollee

Name (Last, First, MI): _____ SSN: _____ Date of Birth: _____

Phone: _____ Street Address: _____

Email: _____ City, State & Zip: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary

	Dental	Vision
	☐ Add ☐ Delete	☐ Add ☐ Delete

Section C: Dependents

				Dental	Vision
Spouse/Domestic Partner Name (Last, First, MI):	Date of Birth:	SSN:	☐ Male ☐ Female ☐ Non-Binary	☐ Add ☐ Delete	☐ Add ☐ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	☐ Male ☐ Female ☐ Non-Binary	☐ Add ☐ Delete	☐ Add ☐ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	☐ Male ☐ Female ☐ Non-Binary	☐ Add ☐ Delete	☐ Add ☐ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	☐ Male ☐ Female ☐ Non-Binary	☐ Add ☐ Delete	☐ Add ☐ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	☐ Male ☐ Female ☐ Non-Binary	☐ Add ☐ Delete	☐ Add ☐ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	☐ Male ☐ Female ☐ Non-Binary	☐ Add ☐ Delete	☐ Add ☐ Delete

Section D: Signature

All information on this form is correct and true to the best of my knowledge. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. I, on behalf of myself and my family members listed on this form, if any, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations, and other terms and conditions of the Dental and Vision plan documents, including the Evidence of Coverage. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, RESIG, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Employee Signature: _____ Date: _____