DELTA DENTAL

Enrollment – Non Voluntary

Group Name	Delta Group/Division Number

A ENROLLEE (Completes 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	☐ New enrollment ☐ COBRA enrollment ☐ Change in enrollment ☐ Reinforcement ☐ Transfer ☐ Retire	☐ Delta Dental ☐ Delta Vision

Birthdate	Sex	Marital Status	Do you have dependent children?		Employee Classification
Month Day Year	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner	☐ 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:	☐ Certificated ☐ Classified ☐ Salaried ☐ Full-time ☐ Hourly ☐ COBRA ☐ Part-time ☐ Retired

Mailing Address Telephone Number

City, State Zip

☐ **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.

Qualifying Date / /

Benefits previously received under Social Security Number (Member I.D. Number) 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 (Last (if different) First Middle Initial	Add / Delete	Sex M F	Birthdate Month Day Year	Marriage / Divorce Date Month Day Year If Child is 19 years or older	Spouse's Social Security Number

Child Name (Last (if different) First Middle Initial	Add / Delete	Sex M F	Birthdate Month Day Year	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 contact.

Enrollee Signature _____ Date _____