DELTA DENTAL®

Enrollment — Voluntary

Group Name
SALIDA USD/CRSIG

Delta Group/Division Number
☐ PREFERRED PLAN - 9678-0142 ☐ PREMIER PLAN - 9678-0141

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 _____

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. For free help, please call Delta Dental at 1-800-765-6003. You may also be able to receive this document in Spanish or Chinese.

IMPORTANTE: ¿Puede leer este documento? Si no, podemos ayudarle. Para obtener ayuda gratis, llame a Delta Dental al 1-800-765-6003. También puede recibir este documento en español o chino.

重要通知：您能讀這份文件嗎？如有問題，我們可請他人協助您。 如需免費協助，請電 Delta Dental 1-800-765-6003 您也能取得這份文件的西班牙文或中文譯本。