

Enrollment — Non 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 <input type="checkbox"/> New enrollment <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Change in enrollment	<input type="checkbox"/> Reinstatement <input type="checkbox"/> Transfer <input type="checkbox"/> Rehire	Please enroll me in the following: <input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision
Birthdate Month / Day / Year	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Do you have dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who is covered: <input type="checkbox"/> yourself <input type="checkbox"/> spouse <input type="checkbox"/> dependent children If Delta Dental, indicate group number: _____		Employee Classification <input type="checkbox"/> Certificated <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Classified <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> Salaried <input type="checkbox"/> COBRA		
Mailing Address _____ Telephone Number (_____) _____ City _____ State _____ ZIP code _____						FOR DELTA USE ONLY Effective Date of Coverage _____ Family Indicator Code _____		
<input type="checkbox"/> 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 there is no contribution required by me for coverage of myself or my dependents. (Exception — See COBRA enrollment) 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 _____