Enrollment — Non Voluntary

Group Name

Delta Group/Division Number

A ENROLLEE (Complete 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 ☐ Reinstatement ☐ COBRA enrollment ☐ Transfer ☐ Change in enrollment ☐ Rehire	☐ Delta Dental ☐ Delta Vision

Birthdate	Sex	Marital Status	Do you have dependent children?		Employee Classification
Month Day Year ___/___/___	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated	☐ 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 ☐ 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 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 ______