



# Dental Enrollment

District Name \_\_\_\_\_

Delta Group/Division Number \_\_\_\_\_

## A ENROLLEE (Complete this section for new enrollment or change of status)

|             |       |                |                               |  |                                      |
|-------------|-------|----------------|-------------------------------|--|--------------------------------------|
| <b>Name</b> |       |                | <b>Social Security Number</b> | <b>Action Requested</b>  | <b>Date Employed</b>                 |
| Last        | First | Middle Initial | (Member I.D. Number)          | <input type="checkbox"/> New enrollment <input type="checkbox"/> COBRA enrollment<br><input type="checkbox"/> Reinstatement <input type="checkbox"/> Transfer<br><input type="checkbox"/> Rehire <input type="checkbox"/> Change in enrollment | ____/____/____<br>Month   Day   Year |

|                                      |  |  |  |                          |
|--------------------------------------|--|--|--|--------------------------|
| <b>Birthdate</b>                     | <b>Sex</b>   | <b>Marital Status</b>  | <b>Employee Classification</b>   | <b>DISTRICT USE ONLY</b> |
| ____/____/____<br>Month   Day   Year | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | <input type="checkbox"/> Single <input type="checkbox"/> Married<br><input type="checkbox"/> Divorced <input type="checkbox"/> Separated<br><input type="checkbox"/> Registered Domestic Partner | <input type="checkbox"/> Certificated <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Classified<br><input type="checkbox"/> Management <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> COBRA |                          |

**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 Event Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month   Day   Year

Effective Date of Coverage  
 \_\_\_\_\_  
 Family Indicator Code  
 \_\_\_\_\_  
 # of Dependent Children Covered  
 \_\_\_\_\_

## B Change to Existing Enrollment (Complete all sections that apply)

Name change    Add new dependent    Delete dependent

Reason for change \_\_\_\_\_ Effective date of change \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month   Day   Year

## C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

| Spouse/Registered Domestic Partner (D.P.) Name |       |                | Add                      | Delete                   | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Birthdate<br>Month Day Year | Marriage/Declaration of D.P.<br>Divorce/Dissolution of D.P. Date | Spouse's/Domestic Partner's<br>Social Security Number |
|--|-------|----------------|--------------------------|--------------------------|--|-----------------------------|--|---|
| Last (if different)                            | First | Middle Initial |                          |                          |  |                             |  |   |
|  |       |                | <input type="checkbox"/> | <input type="checkbox"/> |  |                             |  |   |
|  |       |                | <input type="checkbox"/> | <input type="checkbox"/> |  |                             |  |   |
|  |       |                | <input type="checkbox"/> | <input type="checkbox"/> |  |                             |  |   |
|  |       |                | <input type="checkbox"/> | <input type="checkbox"/> |  |                             |  |   |
|  |       |                | <input type="checkbox"/> | <input type="checkbox"/> |  |                             |  |   |

## 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 comply with the terms of the group contract.

Enrollee Signature \_\_\_\_\_ Date \_\_\_\_\_