ATTACHMENT J

DELTA DENTAL

Delta Dent. a of California

Enrollment — Voluni y

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: ☐ New enrollment ☐ COBRA enrollment ☐ Change in enrollment ☐ Reinstatement ☐ Transfer ☐ 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 ☐ Classified ☐ Salaried ☐ Full-time ☐ Hourly ☐ COBRA ☐ Part-time ☐ Retired

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 _____

Delta 602A (4/96)

ATTACHMENT J (Blank Form)