ATTACHMENT J1
(EXAMPLE 12)

ATTACHMENT J1 (Example)

DELTA DENTAL "Based on Section 22816.7 of the G nment Code"

Delta Den an of California

Enrollment — Voluntary

Group Name
State of California - Exempt Employees

Delta Group/Division Number
9949 - 8601

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

Name

Last First Middle Initial

Birthdate Month Day Year

Sex: Male Female

Marital Status: Single Married Divorced Separated

Do you have dependent children? Yes No

Social Security Number

(Member I.D. Number)

Date ~~Employed~~ Effective Month Day Year

Action Requested: New enrollment; COBRA enrollment; Change in enrollment; Reinstatement; Transfer; Rehire

Please enroll me in the following: X Delta Dental; Delta Vision

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 N/A: Certificated; Classified; Salaried; Full-time; Hourly; COBRA; Part-time; Retired

Mailing Address

City

Telephone Number ( )

State ZIP code

COBRA Enrollment N/A

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

FOR DELTA USE ONLY

Effective Date of Coverage

Family Indicator Code

B Change to Existing Enrollment (Complete all sections that apply) N/A

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

Child 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

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 Sign

Date

Delta 6024 (4-9)