DELTA DENTAL®

COBRA Enrollment Application - please type or print clearly

SCHOOL DISTRICT: _____

EFFECTIVE DATE: _____/_____/_____

ENROLEE INFORMATION

_____ _____ _____/_____/_____
Last name First DOB

_____ _____ _____
Address City ST Zip Code

_____ _____
Phone number Email address

If electing single coverage, leave this section blank

DEPENDENT INFORMATION

Spouse:

_____ _____ _____/_____/_____
Last name First DOB

Children:

_____ _____ _____/_____/_____
Last name First DOB

_____ _____ _____/_____/_____
Last name First DOB

_____ _____ _____/_____/_____
Last name First DOB

_____ _____ _____/_____/_____
Last name First DOB

_____ _____
Signature Date