Non-Voluntary Enrollment Application — Please type or print firmly

DELTA DENTAL
Delta Dental Plan of California

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

LAST NAME | FIRST | MIDDLE INITIAL | SOCIAL SECURITY NUMBER ___ - ___ - ____

BIRTH DATE (MONTH / DAY / YEAR) ___ / ___ /

SCHOOL DISTRICT NAME

HIRE DATE (MONTH / DAY / YEAR) ___ / ___ /

DELTA GROUP NUMBER

EMPLOYEE STATUS
- ☐ Certificated
- ☐ Full-Time
- ☐ Classified
- ☐ Retired
- ☐ Hourly/Union
- ☐ Part-Time
- ☐ Salaried/Non-union

SEX
- ☐ MALE
- ☐ FEMALE

MARITAL STATUS
- ☐ SINGLE
- ☐ DIVORCED
- ☐ MARRIED
- ☐ SEPARATED

Does your spouse have a dental plan? ☐ YES ☐ NO

If YES, who is covered?
- ☐ YOURSELF
- ☐ SPOUSE
- ☐ DEPENDENT CHILDREN

Do you have dependent children? ☐ YES ☐ NO

Mailing address _____ Telephone ( ) _____

City _____ State & Zip _____

B ACTION REQUESTED (Complete all sections that apply)

☐ New enrollment (all eligible dependents must be enrolled)

☐ Change to existing enrollment ☐ Add new dependent ☐ Delete dependent

Effective date of change ___ / ___ / ___ (Month / Day / Year)

Reason for change: _____

I understand that I may be required by the employer to pay for these benefits.

☐ **COBRA Enrollment**

NOTE: If Dependent is enrolling under own Social Security number, the original Enrollee's Social Security number must be supplied.

___ - ___ - ____
PRIOR SOCIAL SECURITY NUMBER UNDER DELTA

Qualifying COBRA event:
- ☐ Termination
- ☐ Retirement
- ☐ Reduction in hours
- ☐ Divorced
- ☐ Widowed
- ☐ Surviving dependent
- ☐ Medicare
- ☐ Over-age dependent
- ☐ Legal separation
- ☐ Other _____

Qualifying date ___ / ___ / ___ (Month / Day / Year)

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

Spouse's Name (FIRST / MIDDLE INITIAL / LAST (if different))	Social Security Number	Add/ Delete	Sex M/F	Birth Date (Month Day Year)	Marriage/Divorce (Month Day Year)
				/ /	/ /

Child(ren)'s Name(s) (FIRST / MIDDLE INITIAL / LAST (if different))	Social Security Number	Add/ Delete	Sex M/F	Birth Date (Month Day Year)	If child is 19 or over, check one: Full-time Student	Disabled
				/ /		
				/ /		
				/ /		
				/ /		

D SIGNATURE (Form must be signed to be processed)

I understand there is no contribution required by me for coverage of myself or my dependent(s). (Exception - See COBRA)

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'S SIGNATURE _____ DATE _____

FOR DELTA USE ONLY

Delta group number _____

Effective date _____

Eligibility code _____

ACSIG for DELTA (8/94)

Instructions: **ENROLLEE — Return both copies of this form to your benefits office. District to return original to ACSIG and keep copy.**