



Enrollment — Voluntary

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 _____

Date Employed _____

Action Requested

Please enroll me in the following:

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: _____

New enrollment Reinstatement

COBRA enrollment Transfer

Change in enrollment Retire

Delta Dental Delta Vision

Mailing Address _____

Telephone Number (_____) _____

State _____

ZIP code _____

City _____

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 _____

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 _____

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

Spouse Name	Add/ Delete	Sex	Birthdate	Marriage/Divorce Date	Spouse's Social Security Number
Last (if different) _____ First _____ Middle Initial _____	<input type="checkbox"/> Add <input type="checkbox"/> Delete	M <input type="checkbox"/> F <input type="checkbox"/>	Month _____ Day _____ Year _____	Month _____ Day _____ Year _____	_____

Child Name	Add/ Delete	Sex	Birthdate	Marriage/Divorce Date	Child's Social Security Number
Last (if different) _____ First _____ Middle Initial _____	<input type="checkbox"/> Add <input type="checkbox"/> Delete	M <input type="checkbox"/> F <input type="checkbox"/>	Month _____ Day _____ Year _____	Month _____ Day _____ Year _____	_____

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.

Employee Signature _____

Date _____