



Enrollment – Non Voluntary

Group Name _____

Delta Dental Group/Division Number _____

A ENROLLEE (Complete this section for new enrollment or change of status)											
Name				Social Security Number			Date Employed		Action Requested		Please enroll me in the following:
_____ Last First Middle Initial				_____-_____-_____ (Member I.D. Number)			____/____/____ Month Day Year		<input type="checkbox"/> New enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Transfer <input type="checkbox"/> Change in enrollment <input type="checkbox"/> Rehire		<input type="checkbox"/> Delta Dental <input type="checkbox"/> DeltaVision®
Birthdate		Sex	Marital Status		Do you have dependent children?		Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			Employee Classification	
Month Day Year ____/____/____		<input type="checkbox"/> Non-binary <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who is covered: <input type="checkbox"/> yourself <input type="checkbox"/> spouse <input type="checkbox"/> dependent <input type="checkbox"/> children			<input type="checkbox"/> Certificated <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Classified <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> Salaried <input type="checkbox"/> COBRA	
Mailing Address _____ Telephone Number (_____) _____								FOR DELTA DENTAL USE ONLY		Effective Date of Coverage	Family Indicator Code
City _____ State _____ ZIP code _____				<input type="checkbox"/> 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)											
<input type="checkbox"/> Name change	<input type="checkbox"/> Add new dependent		<input type="checkbox"/> Delete dependent		<input type="checkbox"/> 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			Add/Delete	Sex	Birthdate		Marriage/Divorce Date		Spouse's Social Security Number	
Last (if different)	First		Middle Initial	N M F	Month Day Year ____/____/____		Month Day Year ____/____/____			
Child Name			Add/Delete	Sex	Birthdate		If Child is 19 years or older (check one)		Child's Social Security Number	
Last (if different)	First		Middle Initial	N M F	Month Day Year ____/____/____		Full-time Student	Disabled		

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 _____	