ELTA DE TAL®

Enrollment — Non Voluntary

Group Name

Delta Group/Division Number

Last | First | Middle Initial | ____-____-____ (Member I.D. Number) | ____/____/____ Month Day Year | ® Change in enrollment ® Rehire ® Delta Vision

Birthdate Month Day Year ____/____/____

Sex ® Male ® Female

Marital Status

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: ______________________

Employee Classification
® Certificated ® Full-time ® Part-time
® Classified ® Hourly ® Retired
® Salaried ® COBRA

Mailing Address ______________________ Telephone Number (_______)______________________

City ______________________ State ______________________ ZIP code ______________________

® COBRA Enrollment

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

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 ____/____/____ Month Day Year

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

Spouse 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
					____/____/____	____/____/____		
Child Name Last (if different)	**First**	**Middle Initial**	**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)

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