DELTA DENTAL

Enrollment — Non 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 (Member I.D. Number)

Date Employed (Month Day Year)

Action Requested: Select

Please enroll me in the following:
- ☐ Delta Dental
- ☐ Delta Vision

Birthdate (Month Day Year)

Sex: Select

Marital Status: Separated

Do you have dependent children? Select

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: Select / Select

Mailing Address _____ Telephone Number _____

City _____ State _____ ZIP code _____

FOR DELTA USE ONLY

Effective Date of Coverage

Family Indicator Code

☐ **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)

☐ 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
	Select	Select			

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
	Select	Select				
	Select	Select				
	Select	Select				
	Select	Select				
	Select	Select				
	Select	Select				

D | Signature (Form must be signed to be processed)

I understand there is no contribution required by me for coverage of myself or my dependents. (Exception — See COBRA enrollment) 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 _____

Delta 602B (Rev. 5/05)